Interview with Vice Admiral Richard Nelson, Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery, July 18, 2001.

HERMAN: You're an Oklahoman, obviously. That's fairly well known. You were born in a place called Perkins.
NELSON: I was born near Perkins.
HERMAN: Near Perkins. Oh, you were born in your own home.
NELSON: Yes.
HERMAN: On the kitchen table, as I understand it.
NELSON: You'd have to ask my mother that, but I was born in my parents' home, which was about 5 miles outside of Perkins. Perkins is a little farming community south of Stillwater, which is a university town.
HERMAN: So you grew up in a farming community. Your father was a farmer.
NELSON: Yes.
HERMAN: And you had intentions of continuing in that?
NELSON: I grew up very active in farming, at least what we were doing. I raised lots of livestock on my own and grew some crops on my own and was very active in the FFA [Future Farmers of America], vocational agriculture.

I started out intending to farm, and then my family . . .My parents are both just high school graduates, but my mother especially aspired to higher education. Nobody ever put any pressure on me, but it was clearly a wish to give me the opportunity for more education. So I decided to become a veterinarian, and that's where I started to college, enrolled in the School of Agriculture at Oklahoma State University in the fall of '59.

About the first day of school, I had to go get a physical from the family physician, who was an internist who happened to also be on the adjunct faculty to the University of Oklahoma School of Medicine. He started working on me, saying, "If you're going to go into veterinary medicine, why not take the easier route and go into people medicine? You only have to learn one physiology system."

I hadn't really considered human medicine until that point. So during that first year of college, I began to switch from pre-vet to pre-med, and actually went to undergraduate just 3 years and was accepted into medical school during my third year and went straight to medical school. So I did college and medical school combined in 7 years.
HERMAN: You graduated in, what, '67 or '66?
NELSON: In '66 from medical school, the University of Oklahoma. I then did internship in Oklahoma City at Baptist Memorial Hospital, which at that time was the biggest, newest, most advanced medical center in Oklahoma, and had been accepted for an internal medicine residency in Oklahoma City. Alice, who was working for the state welfare department, and I were married in '64. We thought we had our life really planned out. We even built a home near where I intended to practice after internal medicine residency. And then a draft notice showed up in the mail.
HERMAN: This was in '67?
NELSON: The draft notice was dated February 16, 1967. Yes.
HERMAN: Greetings.
NELSON: And it says, "Greetings." [Laughs]

HERMAN: I got one, too.
NELSON: Special doctor draft number 41.
HERMAN: They told you it was Navy?
NELSON: Yes.
HERMAN: They did?
NELSON: Yes. I was drafted for the Navy. Being in the Selective Service system since I was 18, I had indicated that, if I were drafted, my service preference was Navy. I'd been in Army ROTC in undergraduate--freshman and sophomore-- and I had no desire whatsoever to be in the Army. My family history is more Navy and Marine Corps than Army, so Navy had more appeal to me. But, in reality, I was not planning on any of it, until the draft notice arrived.
HERMAN: So your life changed instantly.
NELSON: Dramatically. Now, we intended not to let it be a big impact. We, in fact, kept our home. For the first year, year and a half, we kept it open and my first duty station was still in Oklahoma, the Naval Ammunition Depot in McAlester, OK, now an Army ammunition plant.

We kept our home and would occasionally go home on weekends from my duty station and carry on our life.
HERMAN: As if nothing had happened.

NELSON: Yes. But we so enjoyed the people that we met and I enjoyed the work, so during that time I changed my idea of what I thought I wanted to do in a residency from internal medicine to occupational medicine. So we decided, well, we were having a good time. We were meeting interesting people. The pay wasn't wonderful. But we decided that I would take, just to be sure of the residency I wanted to do, I would consider one more tour. I had a 2-year obligation.

We decided to ask for Naval Hospital Bremerton, because I had visited the Northwest before and I liked the Northwest. Alice never had. The Navy, at the time, was so delighted to find a draftee who they could sucker into staying longer that they said, "We'll send you wherever you want to go." [Laughs] So we went to Bremerton, and I was in the hospital there for 2 years, and then . . .
HERMAN: As a GP, though, right, at that point?
NELSON: Well, yes, but that was at a time when we had a lot of b____ who had not completed residencies and general medical officers, so that half the staff, at least, was general practice, general medical officers.

So it ended up being a good time and a good learning experience. I spent about half of it with an internist, taking care of both inpatient, outpatient. I learned a lot of internal medicine that I would have picked up in residency, being the number-two guy to a recent graduate of Balboa's internal medicine residency. And then I spent most of another year in ENT, working with an ENT doc and being his second, so I learned a lot of ENT there.

So, a very good experience. We liked the people that we met. Some of them are still friends, from both first and second tours. We had a good CO.
HERMAN: Who was the CO then?
NELSON: It was Roy Brown, internist physician. He had one more tour after that and then retired. But he was a nice gentleman, a good CO from my standpoint. He wrote me a nice letter for residency.

I applied for residency in 1971, I guess, or for what would have started in '71, and I was not selected. What I was applying for was occupational medicine outservice, and that year there happened to be a number of people who applied who had more time in the Navy than I did and had probably better records. Three of them who got accepted are long gone from the Navy now.
HERMAN: [Laughs] Why occupational medicine? Why were you leaning in that direction? What was it about that that fascinated you?
NELSON: Well, the first duty station I got sent to, I really was practicing occupational medicine.
HERMAN: In McAlester?
NELSON: Yes, because we were running an industrial plant. It was a 7-day-a-week, 24-hour-a-day operation. I was the senior medical officer. I had a second medical officer part of the time with me. We were exposing people to all sorts of chemicals, to noise, and other things. We had a number of special kind of operations, and I started seeing occupational disease, particularly from those dealing—we were a big bomb plant, for one thing. We dealt in lots of explosive materials, and some of those have an ability for significant impact on blood, blood system, on liver, other tissues. Of course, noise is a sensory neural, hearing loss issue. And I got interested in it. Plus, being a farmer, I liked being able to get out of the office. I liked being able to get out and see people at work, understand how their work worked. And personally, I always got a great gratification out of taking care of patients one at a time.

But I saw that if you got into preventive medicine, which occupational medicine is, you could really affect the health of a population of people. You know, by changing the way we did some things in the bomb lines or in the control of the atmospheric conditions, trapping some of the vapors and dust and the like, you could change the health of a population of folks who were working in this.

Well, that had great appeal. So there's a variety of things that affected my desire to be in preventive medicine, occupational medicine.
HERMAN: But it really reached some type of fruition when you got to Bremerton, and you got more involved in it.

NELSON: Well, when I got to Bremerton the first time, see, I was really back doing clinical medicine. Before I jumped off and did a residency in occupational medicine, I wanted to go back to clinical, full-time clinical, treating one patient at a time, and see if occupational medicine was the real choice I wanted, and that convinced me it was. I still loved seeing each patient individually, but I recognized I liked the things that I could do in occupational health and preventive medicine better.

But one of the best things that happened to me was, the first year, I didn't get accepted for residency training. Now, I think I've always led a charmed life, and almost everything that's ever happened to me that appeared to be a big negative turned out to be a strong positive. Well, I didn't get selected, but I was known to the community, I guess, because I'd already gotten to know a number of the people when I was at McAlester, and then I had stayed engaged, even, when I was doing pure clinical medicine at Bremerton.

The head of the Occupational Environmental Health Code—or maybe it's Occupational Industrial Health, I've forgotten how it was termed at the time—Code here, which was at that time Code 73, which is still down at Building 7, but the Code was 73, the head of that was, at

that time, I guess, CDR George Lawton. George needed somebody to head the new branch of occupational medicine, and he knew it was going to be a year before he had an individual he could free up to bring who was fully trained in occupational medicine. And so he asked me. He said, "Why don't you come. Let's get you orders. You come take the job for a year. I can almost assure you, you'll go to residency next year, but you can come here and get a year of looking at it from Washington."

It's probably the most defining year of my career. Alice and I came to town. We stayed a year, made the most of that year. I got to see an awful lot of the Navy in that year, both at sea and ashore. Visited the shipyards, visited a number of ships, worked on some real issues, wrestled with the Department of Labor, particularly over noise-induced hearing loss and claims process for civilian work force. It was a full year, hard-charging stuff, and a lot of education for me. And I ended up working with and getting more introduced to, not just occupational health, but also to the rest of preventive medicine during that year.

I went from that to residency at the University of Cincinnati. That was excellent preparation for residency.

HERMAN: Didn't the Navy have a—they had a center there. They had an environmental center.

NELSON: Yes, the Navy Environmental Health Center, what became known as the Navy Environmental Health Center, which started at Crane, Indiana, with the ammunition depot that was at Crane. That was the origin of the Navy Environmental Health Center. Then it relocated to Cincinnati, adjacent to the campus of the University of Cincinnati, which the University of Cincinnati had one of the—and still has, one of the—what's called Kettering Laboratories, one of the biggest training and research settings for occupational medicine/industrial hygiene-related sciences. So they were adjacent to that for a number of years. Actually, after residency, I was assigned to NEHC for, oh, I don't know, six months, something like that, before I was sent back to Bremerton to be the Director of Occupational Health Department, Occupational Environmental Health.

HERMAN: NEHC in Norfolk? You were assigned there or [unclear]in Cincinnati?

NELSON: No, it was before. See, we've only got one NEHC, and it was Cincinnati. And then in, I don't remember what year, probably '78, '79, someplace in there, —probably '78. —it got moved to Norfolk, which is—it should be in a fleet concentration area.

HERMAN: Any real memories of that assignment?

NELSON: Which one?

HERMAN: Cincinnati, when you were at the center there. Any issues that were really brewing?

NELSON: Well, we were dealing with lots of things. Some of the ones are now things that

we would be looking at from an environmental management standpoint or the sort of stuff EPA would have been involved in. We were looking at, for one thing, the Navy was doing the plans for construction of the submarine base at Bangor, Washington, and we were doing that on an old ammunition depot, a place where, the reason the Navy had all the land was because of the ammunition depot at Bangor, which I'd been aware of because it was one of the major West Coast ports, wharfs, for sending munitions to Southeast Asia during Vietnam. But it also was a site for some storage and de-mil, demilitarization of weaponry.

Consequently, there was a certain amount of material from weapons that had been disposed of on the property. Well, in the past you disposed of it and didn't worry about it. The times were changing, and you had to be fairly public with what you were doing, and it was a time when you were starting to look at things like environmental assessments and the like. So we were looking at what was the impact of some of the de-mil and some of the waste water outflow from some of the demilitarization efforts and all, and what impact were you having on the groundwater. And so we were measuring and trying to get hydrologists involved to look at the water flow, the subterranean water flow, and how, if there were explosives that we could identify in the water or other contaminants, how could we remove those, or how could we prevent their flow, and the like. And so that was a big issue during that time frame.

Also, just the usual things of industry. Asbestos was one that was starting to get some attention. It became more so over the next few years as we got the engineering folks and the line to recognize that asbestos was a hazard that we couldn't afford to keep on our Navy vessels any longer.

The first vessel that we—this is jumping ahead a little bit, but along about '77, '78—I've lost track of time—the USS *Ranger*, is my recollection, was the first vessel that we said we were going to take all the asbestos off of, and I think the only thing left was a few pipe hangars that we hadn't found a good substitute for asbestos. It contained asbestos, but in the hangar portion of it.

So anyway, you were looking at issues that had potential to affect a lot of people's health at NEHC at that time. NEHC was trying to grow and trying to find out who it was, too, but it was really getting more engaged with both the operational Navy, as well as the industrial Navy.

HERMAN: But it was really an outgrowth of the national consciousness.

NELSON: Well, it was more than that. It was really an outgrowth of Navy consciousness, I would say, which was actually a little ahead of the national, on the most part. It lagged a few places, but many places it was ahead. Especially the ammunition side of things was more ahead than, say, the shipyard side of it. Those used to be separate bureaus. When I came to the Navy, what's now NAVSEA, which brings both together—

HERMAN: Was BuShips.

NELSON: Yes, BuShips, and you had BuOrd, Ordnance. And so they weren't married up until a little later. But NEHC started bridging the gap between them before they came together —from an occupational health standpoint.

HERMAN: So you moved on. You moved on from there and went back to Bremerton again.

NELSON: Yes. On my wish list I had a variety of places, including Bremerton, but I had San Diego on there, as well. Because of the various things I'd been doing in my past, Dr. Lawton did me a favor and sent me back to Bremerton. [Laughs] That turned out to be a very good tour, a very extended tour. Alice and I lived there for almost six and a half years.

HERMAN: So you were putting down roots already.

NELSON: Well, we knew that eventually that's where we wanted to live, but we didn't expect to make such roots in the community that early.

But before I went there, in January of '75 I attended a nuclear power training unit at Ballston Spa, New York, went through a sort of radiation health officer training thing for physicians and new radiation health officers, the same one that they sent docs going to the nuclear—of course, we had one nuclear carrier, but we had nuclear submarines and nuclear cruisers at that time that had physicians aboard, and it was the same one that they would send those docs to, and they would send people who they were training to be radiation health officers, too.

That was a very good course, and it gave me good preparation for going in to support both the sub base at Bangor, but more importantly at that time, the shipyard at Bremerton, which was one of our prime nuclear shipyards. It gave me an education, but also credibility with the NAVSEA 08, the Naval Reactors folks, and that's actually a relationship that carries through to today.

HERMAN: And that's not easy, to get a good reputation with those folks. I mean, you have to have some [unclear].

NELSON: No, but it's kind of interesting how that happened. I went to Bremerton. I guess I'd been given good press beforehand. CO was Harold Pairisser [phonetic], a gentleman who I greatly admired. The Director for Administration was Captain Palmer [phonetic]. The two of them actually gave me almost carte blanche.

They had me set up a directorate, which at that time, as you remember, we had Director of Clinical Services, Director of Administrative Services, and really that was it. It was before anybody—nursing came under the Director of Clinical Services at that time. That changed sometime later. But I was the third directorate. They said, "This is important enough. We are a supportive enough operational and industrial setting that we're going to create another directorate. You're in charge of it. Build your office how you want to, with the assets that fall under it."

They gave me oversight of all the clinics, which were mostly industrial clinics. They took care of a few families, but mostly it was taking care of sailors, marines, and civilian work force, and then let me put it together. I mean, they didn't say, "Here's how you have to do it." I had some good folks up there I was able to pull together and use, and we created a real functional organization.

But early on in that, after I'd been there just a few weeks and I was working on getting this organization put together, and they'd given me an empty ward at the hospital, which was just

down the hallway from the CO and DFA's spaces, I was walking down the hallway one day to get to where we were creating this organization of mine, and I heard loud discussion going on in the Director for Administration's office. Jack Palmer is who it was. But it was Captain Pairisser who was so loud, and as I was walking by, he hollered at me. He said, "Dick, come here. I need you."

And who he was talking to was the folks from Naval Reactors who were doing inspection of the shipyard, and they wanted to see a bunch of health records. CAPT Pairisser was saying, "Those are privileged things—information. You cannot have access to them."

The guy said, "These are folks who work in nuclear programs, and we have to see what evidence of their exposure and their physicals and the like." And they were just standoff. I mean, Pairisser was saying, "No way in hell," and these guys were saying, "Well, we'll go to ADM Rickover, then." And so I was put in the middle of this.

Well, the short story is, I said, "Well, maybe I can help you out. I have been through the Ballston Spa course." Well, that gave me credibility with them--beginning credibility with them. I had to prove it yet. I said, "Well, what is it you want?" and they told me. I said, "Well, we can accommodate that. The way we can do it is, we will go pull the records. You tell us what records you want. We'll pull the records, and you and I will go sit in a quiet space and I will review the record and I will tell you what—you ask me your questions and I can tell you, without divulging personal information about these people, what you need to know."

Because what they needed to know were things that, in reality, they should have access to, and now by written agreement, you do have. But the feeling was it needed to be a professional medical person who assisted them. Because some records need a . . .I mean, for one thing, you are dealing with people's personal histories, and there's a confidentiality part to that. But also, there's a certain amount of interpretation that has to go with looking at a medical record, too.

So that made everybody happy. It kept my boss from getting ADM Rickover on his neck, and it satisfied the needs of N8, of Naval Reactors. So that was the beginning of a relationship with them.

I would go to sea on sea trials on nuclear vessels, on surface vessels of all kinds, but on nuclear vessels, too. We were doing overhauls on nuclear cruisers, as well as submarines. And I had great fun at it. I used to occasionally get sent to sea. ADM Rickover would come and ride a vessel that was going to sea on sea trials after overhaul, a nuclear vessel, and all of the COs, they really had a love-hate relationship with him. They sort of almost hoped that he would die, but not on their watch. [Herman laughs] And he didn't want anybody visibly trying to protect his health, and so they would ask me to come ride their ship when they went to sea with him aboard, but for the most part, they'd try to keep me out of his sight. [Laughs]

HERMAN: So you were there for their well-being.

NELSON: For their mental health. [Laughs] And also there for occupational medicine purposes.

HERMAN: Did you ever have any interaction with him?

NELSON: Not much, really. You know, a, "Hi, how are you?" sort of thing is about it, not any deep discussions.
HERMAN: He did come in this office some years ago and had a confrontation with ADM [VADM Willard P.]Arentzen. [unclear]So I'm glad you were able to avoid that.

NELSON: [Laughs] I had no confrontation with him, and I never had an interview, as such, with him. But I did learn all the things that we went through to prepare for a visit from the kindly old gentleman. He had interesting requirements, and . . .

HERMAN: What were they?
NELSON: That's another story. [Laughs]

HERMAN: Oh, that's another story.

NELSON: Everything from the lemon drops to the foul-weather jackets, fruit, and it went on and on.

HERMAN: Yes, he was a terror.

NELSON: There was a check-off list.

HERMAN: So every skipper who would have him come aboard had to make sure that these things were available.

NELSON: You had to do all the right things, yes.

HERMAN: A very demanding fellow, from what I understand.
So you were now really deeply involved in . . .this was your specialty now. I mean, you were an environmental health guy at this point.

NELSON: Yes. And they gave me oversight of the full range, the preventive medicine side of things, as well, there. So it was the full scope of occupational preventive medicine that existed in that.
Now, at that time, that was called Naval Regional Medical Center, Bremerton, and it also took in Whidbey Island. The hospital at Whidbey Island came under Bremerton at that time. The CO up there worked for my boss, Captain Pairisser. And it also took in the hospital at Adak, Alaska, so I had the whole Northwest to travel and to have some oversight on the occupational health and preventive medicine kinds of functions. We really did that pretty much with minimal input or support from the EPMU, at that time down at San Diego. So I had that whole scope.
I also had, after I'd been there a little bit, created a billet for another military-trained physician, and I got an epidemiologist in, who then learned a lot about occupational medicine. But the value was to have a preventive medicine-trained doc there along with me.
So it was a great time. I had a good time. I had two additional duties that fit right in

with my job. One, I was the first medical department head for the submarine base at Bangor, as we commissioned it. I was part of the commissioning crew for that. It was after that that they put a . . . Admiral Arentzen, in fact, was involved in making the decision that Navy medicine would not take responsibility for that clinic at the submarine base, because there was still some uncertainty about what the costs were going to be and a few things, as I understood it. And the decision was made to turn that as fully owned by the submarine base, and a Navy medical captain was sent in to be the head of the clinic there. So he became department head and I went back to my full-time job.

The other added job I had was as medical department head for the shipyard, Puget Shipyard. In both of these, I was every week involved in work and in meetings with the leadership of both the sub base and the shipyard. And then we had clinics scattered around, like the torpedo station at Keyport and spent time at Whidbey with the aviation side of stuff, and even up to Adak, Alaska, with things going on there.

HERMAN: So you didn't get stuck behind a desk, by any means.

NELSON: No. No, no, no. We were out and about.

HERMAN: You were all over the place. You had quite a variety of . . . so it kept things pretty interesting, I would guess.

NELSON: It was very interesting. Up until the last few years, I'd been to sea on almost every class of ship that the Navy had, including going to sea and climbing a Jacob's ladder to get on board a troop carrier, and I'd done that because of a hepatitis outbreak in the Army troops aboard a ship that was coming back. They were Army troops coming back to Ft. Lewis, Washington, and an internist and I went to sea, got a tug out, I think it was a seagoing tug, and boarded that thing on a Jacob's ladder. Interesting experiences. But I had been to sea on various carriers and everything.

HERMAN: What was the outcome of that situation with the hepatitis?

NELSON: Oh, we figured out we could confine it. It was in a food service worker, which is the scary part, but it was one that we could do a certain amount of . . . We used a bunch of gamma globulin and then followed a number of people for a while, but it ended up, we did not stop the disembarkation of the folks and like. So it had a good outcome, but it was just an interesting way of going to sea. [Laughter] I mean, they already were ready with . . . They knew that they were going to have a band on the pier waiting for them and a few more things, and the general in charge of them was just beside himself that we might have to keep them quarantined aboard ship for a while. [Laughs] It had a good outcome, but it was most interesting.

Did a lot of stuff like that. Had a wonderful time. I also got engaged in the community, not just the Navy community, but the community. Even though we were there six and a half years, we moved three times, and my kids were in probably four different schools because of the growth of the school system with the submarine base being built. I ended up as the president of

a community club two years running during that time. My wife, Alice, built up a business. She was a real estate broker. We had a lot of fun.

HERMAN: I can see why you're going back.

NELSON: Well, we still have an awful lot of friends there, both military retired, and still active, and also community people.

HERMAN: So you ended up coming east again after [unclear].

NELSON: Yes. I had been threatened with getting orders to BuMed.

HERMAN: That's scary.

NELSON: I was not really wanting that. I had done a bunch of work on asbestos issues and some of those things and had developed some credibility, because we were doing things a particular way, and we had business plans on what we were doing and could show that we were accomplishing what we said we would, which wasn't always true of every place.

The guy who had been one of my COs at Bremerton, Bob Elliott , now retired RADM Robert Calhoun Elliott, I believe, Medical Corps, Bob was Chief of Staff here at BuMed. I believe the Chief of Staff is what it was called then. He came here at the end of Admiral Arentzen's time and was here for part of Admiral Cox's time, I guess.

Anyway, I'd been here doing some business of some sort in Washington and stopped in to see Bob early one morning. And we were talking, and he said, "Have you met Admiral Clint [Clinton H.] Lowery?" who was then, I don't know, probably at that time I think it was Med 05, probably. I don't think it had become Med 02 yet.

HERMAN: It wasn't 02 yet.

NELSON: You know, it went from 7 to 5 to 2 over time, and I lose track of when. But he was the guy who has the job that Steve Hark [phonetic] has now, effectively, had oversight of operational medicine and all things that came under that.

And I had not met him. I had known his predecessors, but I had not known him. He said, "Well, let me call up, and let me get you a chance to go down and visit with him."

It was early morning. It was, I don't know, seven o'clock or something. He got a hold of Clint Lowery, and he said, "Yes, come on down."

So I went down and just visited with him. We talked a while, and talked about things and what was going on and why I really didn't necessarily want to come to BuMed Code. But, I mean, I never knew that you had a choice. I always figured you went where you got ordered. But if they ask your opinion, you could express it. And we got along fine.

That was all I heard, until I got this telephone call from him along about February—yes, February of 1981. He called me and said, "How would you like to be the commanding officer of the Navy Environmental Health Center?"

Well, yeah. I didn't hesitate. I said, "Sure." Now, I've learned since then that I ought

at least say, "Well, let me talk to Alice," but I honestly did not say that. [Herman laughs] I said yes, because I figured I was still four or five years away from getting a shot at being CO at the Environmental Health Center, because I had not yet reached fourteen years of active duty. I had just barely been . . . I made captain in October, I guess, of 1980, although in those days, you . . . it turned out I got promoted on the day the selection board met. But in reality, I didn't get promoted, wearing it, until some months later. But anyway, I was a new captain by the time he called.

He said, "Well, I haven't told the current CO he's leaving yet." [Laughs]

[Begin Tape 1, Side 2]

NELSON: Anyway, after the admiral had called me, Admiral Clint Lowery, and said that, "How would you like the job?" and I think I almost shocked him by saying yes. And then he said, "Well, I haven't told Captain so-and-so that he's leaving yet, but we're concerned about . . ." Several things had come up that he had heartburn about and were causing him grief.

So he called me back in a couple of days and said, "We're going to send you orders." And so I detached on the Fourth of July from Bremerton and went to Norfolk with my family to be CO of the Navy Environmental Health Center. That was 1981.

I'll tell you, moving from the Northwest to Norfolk, Virginia, in July is a miserable thing to do. We thought we were going to die. And that turned out to be a very interesting tour. It was one that was a little bit hard on my family, because I moved them into a new house, which took essentially all my money to pay for this house. By that I mean the monthly . . . If you remember, 1981 interest rates were looming around 15 percent.

HERMAN: That's right. You weren't provided quarters for this job?

NELSON: No, no, no. We bought a home in Virginia Beach, and I drove . . . The Navy Environmental Health Center at that time was on NOB, the operating base. Great place, great location. Lousy buildings but a great location. And I was spending, you know, 16 hours a day at work and then traveling some, because by that time the Navy Environmental Health Center had the Disease Vector Ecology Control Centers, as well as the Environmental Preventive Medicine units as subordinates to it. Plus, there was a lot of meeting and greeting and dealing with folks around the Navy, both the operational side, the industrial side, the hospitals, too, some from a standpoint. So I basically dropped my family off and was gone for the next six months or so.

Along the way, I figured out that the reason my predecessor was in trouble was not because of what he did, but because of what he let his XO do, who was my XO.

HERMAN: So you inherited the problem.

NELSON: I inherited an XO who had a different set of priorities than mine and a different vision than what I thought the organization should have. And so after about three months, I relieved him, and because of my concerns about the organization's, perhaps, maybe abuses of resources and the like, I called in the . . .BuMed had an IG function at that time, I guess it had a

little different name. I called them in, and I called in the Naval Audit Service to look us over.

They didn't find anything that we didn't find, but they documented some discrepancies that we needed to deal with in getting our financial behaviors and personnel behaviors corrected, in line.

And unfortunately, when you point out something like that in the public, or —in the open, Congress wants to take credit for it. I should be careful saying that, since I'm not retired yet and have a congressional hearing this afternoon. But Congress decided, since we had misbehaved, even though it was two years after the fact that they took action on it, they docked us a million dollars out of our little budget. Well, I had already cleaned it up. I'd turned money back, I'd done all sorts of stuff, we had, as command, and then Congress took a swat at us. [Laughs]

I went out one Sunday morning, long after this was all taken care of and we were clean, doing great stuff, in our opinion, and went out, picked up the Sunday paper, and above the fold it had the headlines, "Small Navy Command Misappropriates," or something about like that. My God, I looked up and down the street to be sure none of my neighbors were out doing the same thing I was, ran back in the house and sat down and read that article. [Laughs] Well, once you got in the article, it wasn't near as bad as the headline sounded, but this headline would scare you to death. Anyway, that was an interesting time.

By the time that tour was over, it was a great tour. Had a lot of fun, got to know some of the fleet guys. Also got to know the first Fleet Surgeon while I was there--Admiral Bill McDermott , and at the same time, Admiral Jim Zimble, who was the Medical Officer of the Marine Corps, and then he became the Fleet Surgeon while I was still CO of NEHC. Both of them, we got along fine, and I did a lot of work for them.

We did a lot to support the operations in Beirut, which from a preventive medicine standpoint, was a great success in disease prevention and control. We, within hours, were prepared to support who was the Fleet Surgeon then, and thus the Joint Surgeon out of Atlantic Command at that time, by the time of Grenada, was Admiral Zimble, and we were ready to support them in that operation with the deployable preventive medicine asset community. That was one of the things I was proud of, is we really became an operation that could deploy on a moment's notice, with all the laboratory assets and people ready to go that we needed for preventive medicine, a deployable preventive medicine unit.

HERMAN: And the DVECCs were up and running by that time.

NELSON: No, the DVECCs, they were all functional units. They just had not been formed into a functional—this was when they were put together into one organization—. Great people, very capable people, and we formed them into a more deployable, capable outfit, with everything, knowing what the assets were and that they were on the shelf and that we exercised with them and knew our people were ready to go. It was good.

HERMAN: I got to know some of those folks, Herb Bolton, Lance Sholdt, and those guys.

NELSON: Oh, yes, weren't they great people?

HERMAN: Great folks. In fact, we stopped to see the Sholdts last summer.

NELSON: In Arizona?

HERMAN: In Tucson. We were in Tucson, and we stopped to see him.

NELSON: I have not seen him in several years, but one of the people that I have great respect for.

HERMAN: Wonderful, wonderful man.

NELSON: Yes. Yes. Well, that was a fun time.

Then I was coming to the end of my third year there. Or I guess before coming to the end of it, it was back in November of '83. Admiral McDermott was here at Naval Medical Command at that time. They'd split out BuMed, or split out the Surgeon General out of here over at the Pentagon. Anyway, he asked me to come see him. So I came to see him, and he said, "What do you want to do next?" sort of thing.

I said, "Gosh, I'd like to go be CO someplace else."

He said, "Well, I want you to come to BuMed." By that time, Med 02 had been stood up, and he said, "I want you to come be Med 24," so have oversight—. I said, "Aw—."

HERMAN: You knew your luck had just run out.

NELSON: Yes. I told him, I said, "First off, that's unfair to whoever's my relief as CO at Environmental Health Center, because Med 02 sort of has oversight of the Environmental Health Center, and here you're going to put me, as the last CO, overseeing my relief, and that's probably not going to be fair to that individual."

He said, "Ah, it doesn't matter. I want you to come be that. Think it over. Come back and see me in a few weeks."

So I thought it over, came back to see him, said, "I still don't want to do it. Partly, I'm not sure who you're going to have as Med 02, who the flag's going to be there. And, you know, I don't want to work for somebody who doesn't have an interest in the kind of work we're doing."

He said, "Who would you like it to be?" [Herman laughs] He said, "Who would you like it to be?"

And I said, "Well, there are two guys who I think are likely selections for flag this year, either one of who would make a great Med 02."

He said, "Well, who's that?"

I said, "Well, okay, it's Paul Caudill and Jim [James K.] Summitt." I said, "I know both of them. I've worked different issues with both of them, and I think either one of them would be great."

He said, "Well, fine. It's going to be one of those guys." Now, this was before the flag board had ever met. [Laughs]

HERMAN: That's great. You're a king-maker.

NELSON: No. No, he probably wouldn't want me going around saying that, but I thought, "How in the world—?" I thought, "He's just saying that." Well, it turned out they both were selectees that year, and Jim Summitt became Med 02, and we had a great relationship. But he only stayed there a year.

HERMAN: And Admiral Caudill became deputy.

NELSON: Yes. I don't remember—he didn't immediately.

HERMAN: Not right away. When Admiral [Lewis H.] Seaton took over, he was over at the Pentagon. That's when they were under—he called it under house arrest at the Pentagon.

NELSON: Yes. [Laughs] Anyway, —all that's to say that Bill McDermott was right. Those two guys got selected and, sure enough, Jim Summitt became Med 02. I worked with him for a year, and then he got moved to Medical Officer of the Marine Corps in August, beginning of August or late July of '85.

HERMAN: He replaced Admiral [Joseph S.] Cassells, I think.

NELSON: Probably so, because Joe Cassells came over here to replace McDermott, who retired. They didn't have somebody to put in Med 02 at the time, and Jim Summitt had put me forward for the job to be his relief, so I was. I became Med 02 in the summer of '85, and I stayed in that job until January of '88. They brought in a new flag to replace me in January '88.

HERMAN: I'd like to stop it here, because I have—

[End of Interview]

Interview with Vice Admiral Richard Nelson, Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery, July 23, 2001.

[Begin Tape 2, Side 1]

NELSON: I don't remember exactly where we were. Had I become Med 02?

HERMAN: You had just become Med 02. That's where we ended.

NELSON: Okay. Well, I was Med 02 from summer, it was about July, first of August, maybe, of '85, until in January of '88. It was an interesting time. It was when we had the split between the Surgeon General and then what we called the Naval Medical Command, which was what's here on the compound. The Surgeon General was over in the Pentagon, but he had some of his staff in Building 6 here at the time, as well, so it was kind of a curious division, and nobody knew how the labor got divided. Supposedly, the SG was policy and Naval Medical

Command was implementation. That probably didn't work very well, because we were used to actually holding, kind of, both of those, from a Washington perspective, in one organization before that, and in '89 we brought that back together.

I spent that two and a half years in Med 02 really engaged in much of the same sort of things they are today, even though today it's gotten a little broader-scoped with the addition of the drug programs and what's now Med 27, which is the readiness piece of what we do. But during that time frame, one of the things we were engaged in was work on the hospital ships. Some of the oversight of that came under Med 22, which was Rich Hooper during much of the time that I was Med 02. The *Mercy* got completed during that time, and we participated in sending her on a humanitarian voyage that took her through the Philippines.

HERMAN: That was when Dr. [Donald L.]Sturtz was the CO of the hospital ship [USNS *Mercy*], as I recall.

NELSON: Yes. It was then Captain Sturtz was the CO under way, and it was while he was gone on that mission that he was selected for flag; that's my recollection.

HERMAN: To go back just a little bit to the hospital ships, did you have anything to do with the planning or had that pretty much been done by the time you arrived?

NELSON: No, the planning was done. Construction was under way. But doing things like trying to be sure you've got the rock [?] and the POE [?] right and reviewing the staffing, reviewing how you would deploy them and use them and the like. A lot of that went on during the time that I was Med 02.

A lot of other things were going on at that time. We started what were called the Aerospace Medicine Problems Course, as I recall, or Aviation Medicine Problem Course, which started an annual get-together of both flight surgeons and aerospace medicine docs to really deal with and discuss and get educated on current issues in aviation medicine. So it was kind of an exciting time to be Med 02, a lot of good stuff going on in R&D at that time. The R&D community was larger at that point. I think currently it's better focused, but at that time it was larger and a little more widespread. I had just come a year before from NEHC, so that was one of our subordinates. And we had a fair amount of stuff going on in the Physical Review and Evaluation Division, what's now Med 25.

So it was a very interesting time. It kind of broadened my horizons on a number of the things that were going on in Med 02. Captain [Robert L.] Bumgarner, Bob Bumgarner, was Med 21, Undersea Medicine, and one of the very important things that came out of that time frame was a new direction on the independent duty corpsmen, both surface and submarine. A new instruction was put out that had a lot of work in it that required currency in their experience and some regular oversight and update, something that has been refined a little more since then, but really had its origins in Bob Bumgarner and the work that he pursued with that.

We really strengthened our ties with Naval Reactors during that time frame, and my recollection is around that time we renewed the agreement between Navy Medicine and Naval Reactors about how we work together. So it was a fun time to be Med 02, except for some of the things going on in medicine at that time.

During that time frame, there was a lot of turmoil, first that had driven the separation of the Surgeon General and what was then called Naval Medical Command into the two functions, which created a tension that I don't think was necessary, or at least from my perspective at the time. But then there was a further separation in that there was a decision made that we would look at, I guess, practitioners in particular, in two different groups. We would look at health professionals and we would look at clinical professionals, and you'd get dual-tracked and you would be one or the other. In fact, during that time they selected flag officers from both tracks. And yet it was very confusing, because what was the track going to be for a clinical professional flag officer? We had tried that before and never been very successful at it, by accounts I had heard, anyway. So here we were doing it again, apparently, at the behest of the Secretary of the Navy.

And then there were guys like me who didn't fall into either one of the categories. We fell in the middle someplace, it seemed like. So when they screened people to screen them for one or the other, I basically screened for nothing, even though I had previously screened for major command. [Laughs] At that time, we had command divided into various categories, and I'd screened for major command and had been almost given orders, twice almost given orders, to be the commander of one of our geographic commands, which we had at the time.

HERMAN: Which one was that?

NELSON: I was supposed to have been headed towards Hawaii. I forget what we called it--PACIFIC Geographical Command, I guess. That fell through the first time, I think probably because I angered the Surgeon General, and then later because we killed the program, or were about to. [Laughs]

So it was an interesting time, and I enjoyed it. I enjoyed being Med 02. But I got frustrated in the system at the time, and I almost made a decision to retire, and my family talked me out of it, said I should go away on a high note, not frustrated. I really couldn't see where I would go next after that.

HERMAN: This is after 02?

NELSON: Yes. I was coming up towards the end of my time at 02, and I already knew that my relief had been identified and was coming in, and he was one of the new flag selects.

But we had a new Surgeon General, Jim Zimble, and I had worked with him in the past in Norfolk. In fact, he and I were both down in Pensacola in the fall, late fall, I guess, or early winter of '87, so it would've been along in November or December, something like that, of '87. He stopped me one evening down there and said, "I want to talk to you a minute. I want you to go talk to Admiral Ming [Erh] Chang], the Navy Inspector General. We need to put a new head of the Medical Division. (I've forgotten the name of it at the time.) We need a new head for the Medical Division there, and I'm interested in nominating you for that job."

HERMAN: This was at Pensacola?

NELSON: He and I were visiting Pensacola at the time. We just happened to be together in

Pensacola, IG, early.

HERMAN: Where was the Medical Division? Where was that?

NELSON: Oh, that was Naval IG, I'm sorry. The Naval IG here in town. It just happened Jim Zimble and I were both at this course, the Problems Course in Pensacola at the same time, and he chose that point to stop me, and I mean literally. One night we were going out to dinner with several people, and he stopped me and held me back and said, "Let's talk a minute." He said, "I want you to go visit Ming Chang at Naval IG when we get back to town and interview with him for this job." And he said, "You do that and [be] successful at that job, and I will give you a good job coming out of that, if you'll go do that for eighteen months."

Well, I'd been told eighteen months when I came to town for Bill McDermott, and five years later I was still here.]Laughs] Well, three and a half years later at that point.

HERMAN: Credibility was not good.

NELSON: [Laughs] Well, I learned if you want a friend in Washington, you get a dog. But Admiral Zimble asked me to do that, and I told him, I said, "Look, I've heard all the stories about Admiral Chang. I have talked to some people who work for him. I have not been in a hospital for--let's see, at that time it had been six and a half years since I'd been in a hospital.

HERMAN: Bremerton was the last place you'd been.

NELSON: Yes. "And I don't think I'm qualified for the job."

He said, "You can do this job just fine. Go talk to Admiral Chang."

Well, I got back to town. It was winter, cold, and I hadn't called Admiral Chang yet. A week later he called me up and said, "How come you haven't been over to see Chang yet?"

So I called and made an appointment with Admiral Chang. I don't remember the date I went to see him, but it was during a snowstorm, right after a snowstorm here in D.C., and the government buildings were basically closed down. But I went to the Navy Yard to see Admiral Chang, and there were only three people that worked in his office, he and his aide and the lawyer. Anyway, I went to visit Admiral Chang. I'd already visited with his staff before that. I knew some of their concerns. So I figured I was retirement-eligible. I had no reason to be anything other than straightforward.

Admiral Chang acted like I was already the guy for the job and this was just a formality. He welcomed me aboard, and I said, "Well, you should know that I have talked to a lot of folks and I know of your reputation, and I'm concerned that you have a reputation for being really tough on people, and I won't tolerate that." [Laughs] Well, I've always been sort of outspoken. That's probably why I was in trouble with the previous Surgeon General.

Anyway, he was all taken aback and just terribly hurt that anybody would think he was less than extremely friendly. We had a very frank discussion, and he still called Admiral Zimble up and said I was good to go.

HERMAN: [Laughs] Even after that.

NELSON: [Laughs] Yes. So in January I reported in over there, and I spent a year and a half there, and most all of that after the first few weeks, as the director of that division, which was one of six divisions in the Naval IG.

It was at a time when BuMed . . . Navy Medicine did not have its own inspector general, so we were the IG for Medicine. I had a staff of about, I guess altogether it came up to about a dozen people. We had dental and the whole scope of medicine, and we had oversight of the environmental side of things that was actually operated out of the Navy Environmental Health Center, an arm of it, but belonged to the IG.

That was a very interesting time. It gave me another perspective on Navy Medicine, because I got to go visit a lot of our hospitals and clinics and also the geographic commands, and I got to see a lot of Navy Medicine from a different perspective. So it was very educational for me. I also watched how the bigger IG approached organizations like Navy Medicine, and I saw that we needed to change the way we did that some, in my opinion, how we investigated or surveyed Echelon 3 activities, and tried to influence some changes in that. Admiral Chang and I were always at each other's throat over that sort of thing.

HERMAN: What were some of the issues? Obviously, Admiral Zimble decided on you to go and interview for this job. What were his concerns at the time?

NELSON: Admiral Zimble's?

HERMAN: Yes. What was going on with the IG and Navy Medicine that he thought you should be there?

NELSON: Admiral Chang and Admiral Zimble didn't specifically give me any guidance going in. He just said, "You're who I would like to send there." He didn't say, "I'm concerned about such and such," exactly. I guess we talked about some of my concerns, which maybe were his concerns, and that is that Admiral Chang seemed to not like Navy Medicine and seemed to have an ax to grind with Navy Medicine. You know, this is Dickie Nelson's opinion, but Admiral Chang had an ability to be a killer bee on people and their careers at times, and I think the concern was that we needed to do the right thing, which we did have some problems, but we needed to do the fair thing. And so he, I think, wanted maybe a view with some medical integrity in it would be my guess. I don't know, and I may be over-guessing what he wanted.

But we also had concerns about the organization. Jim Zimble inherited this CPHP organization and the GeoComs, with hospitals below that, and then also the split between the Surgeon General in the Pentagon and the Commander of Naval Medical Command here on what's now BuMed compound, what in law never changed from BuMed. So we had, I think, what he saw as a dysfunctional organization, but also people who were wanting to do damage to it.

At that time, Medicine worked for Medicine, the hospitals worked for the GeoComs, GeoCom worked for Naval Medical Command, Naval Medical Command supposedly worked for the Surgeon General in his OP-93 hat. So I think Jim felt like he really didn't have the influence that it would appear he had over the whole workings of Navy Medicine because of the split in the jobs, but also we did not have the confidence of the line. And so I think all those

things were of concern to him.

HERMAN: Wasn't that about the time of the blue-ribbon panel, also?

NELSON: Yes. Let me tell you a little bit about that, from my perspective. One day early in 1989, April of 1989 . . . I could go back and almost find the date for you. I'm sorry, it's probably in March, probably in late March, early March maybe. Admiral Chang came to me one day and said, "Dick, I want you to write a report about the need for reorganization of Navy Medicine, and here's what I want it to say." [Herman laughs] Admiral Chang always told you——it was very easy to work for him if you were willing to work this way. He would tell you the answer, and then all you had to do was build the report to support that. [Laughter]

Well, I heard him say all this, and I said, "Well, Admiral Chang, I think it's important, if we're going to relook at how we're organized, that we look at other organizations and how other folks are organized, and kind of do a study of that." I was getting into TQM at the time, total quality management, which in the Navy we sometime thereafter started calling TQL, total quality leadership. Anyway, I thought you ought to do a little work on continuous improvement, or at least look at what the performance improvement issues were that you could bring to this, instead of just drawing new diagrams.

He said, "Fine, that's a good idea. Go do that. But here's the answer I want." [Laughter]

Well, my staff and I really got into this. We went and interviewed folks in the Air Force Surgeon General's Office and looked at how Air Force Medicine was organized and the pros and cons. We went to the Army and did the same thing. We looked at some private health industry organizations. We were charging away on this, and he came back and said, "I want that report. I want to send a letter to the Secretary——da da da da."

Well, we ended up writing a letter, which I still have the original draft of put away, that started the blue ribbon panel. We wrote a thing to the Secretary, expressing our concerns about the current organization of Navy Medicine, the need for——I've forgotten the wording, but a need for streamlining the organization for line engagement. Actually, a simple letter, but what was needed by the Secretary, I guess. I think it had all been preworked between the IG himself, the Secretary, and the Surgeon General. So we put together a letter that was then used as the basis to start the process of blue ribbon panel. I participated in one of the panels of that, until I left IG.

But it was very interesting to watch what happened with our little piece of work. I don't know if we would have exactly predicted the outcome. I think Admiral Zimble, behind the scenes, drove a lot of the way that that was looked at, and I think the outcome was, in the long run, much better for Navy Medicine. We are still in that organizational configuration that came out of that. The power hospitals and clinic commands and our dental centers worked for the line. They don't work for BuMed, as such. I certainly influence what they do. We give them technical support and technical guidance, direction, and we resource them. That was the piece that I thought the line should have picked up, and they didn't, and we since have become part of the Defense Health Program. So we resource them, but their fitness reports come from the line. Now, I certainly have the ability to influence an awful lot of what they do, and I talk to their line bosses and the like, but we have an awful lot more credibility with the line than we had in all my

previous years before that of being in Navy Medicine.
HERMAN: This whole process——the blue-ribbon panel, Admiral Chang, his input, your input, Admiral Zimble's input——fundamentally changed the relationship between Navy Medicine and the Navy.

NELSON: Yes. Yes, it certainly did, and it went into effect, became effective 1 October 1989. I got to see that from a different perspective, because in July of that year, 1989, I became the Commanding Officer of the Naval Hospital at Bremerton. Now, that was my reward, if you will, for having survived Naval IG. [Laughs]

HERMAN: So Admiral Zimble followed through on his promise.

NELSON: Well, he did, but he did it in an interesting way. He was going to send me, under the old organization, he was going to send me——I told you that twice I almost got sent to Geographic Command. Well, he was going to send me to be——I guess there were four of the Geographic Commands, four out of the eight, that could be 06s, and I was an 06, and he was going to send me to be a Geographic Commander in Hawaii, that had the Pacific. And so once the blue ribbon panel was reporting out on its organizational structure, those GeoComs were going away. So he said, "Well, it looks like you did yourself in." [Laughs] He said, "Where else might you like to go?"

I had said in it, I was interested in going Geographic Command, but there were other things that interested me. I'd like to go to a medium-sized hospital, such as Naval Hospital, Bremerton. I felt a little bit sorry for the sitting CO, but not sorry enough to say "no, thanks" to the offer. He was coming up on two years there, and as far as he was concerned, he was going to stay another year; and the next thing I knew, he had orders out and I had orders in. And I was delighted to have the orders.

I went with an agenda, though, and, fortunately, it was an agenda well supported by the SG and the Deputy SG at that time, who was [Robert W.] Bob Higgins. I went with an agenda to restart the Family Practice Training Program there that had been stopped a couple of years before that, two or three years before, stopped for the wrong reasons, I felt. We certainly had a need for family physicians in the Navy, but at the time some of the MedCom leadership didn't think it was as important, is my recollection. Anyway, so I went to Bremerton.

I went there with, I think, two-year orders, but I went there with the desire to stay three and retire, because Kitsap County, the Northwest, was where I wanted to call home, Alice and I did. So we went there hoping to be able to stay three years and retire. One of my goals had been to retire by the time I was early fifties, retire from the Navy. Anyway, all that's to say that we went to Bremerton, just had a wonderful time. Had great bosses up there. The line——I had two different line bosses during the only nineteen months I got to spend there. Both had two jobs. They were both the Commander of Naval Base, Seattle, which was the job that I reported to, but they were also Submarine Group 9 Commanders, and so they had the Tridents in the Pacific.

So things were going well. We were really starting to institute continuous improvement in how we did business up there. The staff and I were having—at least I was having a great time. We seemed to be getting along fine. We were doing all these things to improve how we

provided service to the fleet and to the operational forces in the Northwest and also improving, increasing our beneficiary care to our peacetime health care benefit, and having a pretty good time at it and getting along well with the folks at Madigan [Army Medical Center], which was our tertiary care facility for referral purposes, and I was just about as satisfied as I could be in personal gratification of the job.

I was holding captain's calls early August or the end of July. I used to know the date; I guess it was early August. I was in call with the enlisted group, and a young petty officer; I don't think he was even petty officer. I think he was probably an E-3. He said, "Captain, I'm hearing about the stuff going on in Southwest Asia, the Iraqis moving into Kuwait, and there's rumbling about us deploying forces, talking about the Navy sending things in there, the Marines going in to support the Kuwaitis. Do you think we'll activate the hospital ship?"

I had 120 people or so who were assigned to the *Mercy*, support for the *Mercy*, out of Oakland. I said, "No, we're not going to deploy the hospital ship. Do you understand what it takes to get one of those under way and the number of people it takes and all that? I think there's a low probability of us doing that."

Well, I think it was the next day they announced they planned to deploy the hospital ship. [Laughter]

HERMAN: You wished you could take that back, huh?

NELSON: Well, I made no bones about the fact that I was wrong. I mean, it was obviously very apparent. And I was really proud of my staff. We prepared those folks. I think it was a weekend we had to do it, because I think it was on a Friday, the day of the change command for the Naval Dental Center at Bremerton, that we got the word; it was right around then, that afternoon maybe, we got the word to get our people ready to deploy, and we had them ready. Within forty-eight hours, they were ready to be on their way. We had all the legal done, all of their family things taken care of. We had everything but how we were going to cover the patients that stayed at home. We had everything else taken care of.

We got them under way, and then we started getting [unclear] to send people to the Marines. The folks that went to the *Mercy* went, and then the *Mercy* started to get under way within their five-day ROS (Reduced Operating Status). She started getting under way, and they had a screw problem. She hadn't even gotten out of San Francisco Bay when she had problems and had to be brought back and repaired. So they sent many of my folks back to me, and then when she actually got under way, they made the wise decision to fly people out to meet her. And so I did get some of those people back for a little while before they left again.

HERMAN: How long was it in the yard to be fixed?

NELSON: It was a short time, but my recollection is, during that time the Pacific Fleet Surgeon convinced folks that the better decision was to fly much of the contingent to her out in the Philippines or Singapore or someplace—I've forgotten the details of it—rather than everybody ride her for two weeks to get out there sort of thing, because it took a long time for those, especially for her, to cross the Pacific and get all the way to Southwest Asia.

HERMAN: Seventeen knots downhill with a tailwind.
NELSON: Yes.

HERMAN: Well, they did the same thing with the *Comfort*. They flew them out to Rota, and they picked the ship up in Rota, which made a lot more sense.

What did that do for your hospital? Your hospital is stripped—not stripped, but . . .

NELSON: No. Before it was all over, I think I'd lost more than 250 folks because I sent a lot to the Marines, some to other ships, like the casualty-receiving ships. But it took time for all this to occur. They didn't pull them all out in the first few days.

And then in late August, we got a call-up of the reservists, and we received a large contingent of reservists, and more came over time, but a large group, initial group, who were headed—they were not ones that been assigned to Naval Hospital, Bremerton as their platform to exercise on or anything. They had actually, most of them, been assigned to California hospitals. But they came, and the person who was the senior officer of that reserve contingent that came to us was then Commander, Captain-select Joanne Levin-Homme. They were kind of a little bit befuddled, because they didn't know anything about Bremerton, and that wasn't where they were focused as a group.

But they came, and my staff was saying, "Oh, my God, here come the reserves. We're going to have to cover for them."

I kept telling the folks that worked for me, "You know, I think the reserves are going to be okay. I've been around the reserves before. A lot of extremely capable people in the reserves."

Well, obviously it didn't take very long for the people who stayed behind at Bremerton to recognize the quality of reservists we had. In fact, my DNS (Director of Nursing Services) was retiring, and I said, "Let her retire on time," and I made Joanne Levin-Homme the DNS at Bremerton during the time that she was recalled to active duty. She was extremely capable, a person capable of a lot more.

We had in that reserve group a medical repair technician. I had an electrical engineer. He was a reserve corpsman still. I had several physical therapists who were enlisted. They'd stayed in the reserve as they had done their education. We had tremendous reserve assets, and predictably, when it came time for our folks who had deployed to come back, my staff didn't want to give up the reservists. [Laughter] It changed the attitude of a large group of people about the quality of folks in the reserve, why they were in the reserve, and their willingness to serve their country.

We had a good time. We looked after the families that were left behind. We took care of our patients, and we got a lot of support out of the community, both the Navy community and the Kitsap County community at large. It helped engender a lot of pride in what we were about. It was a wonderful time to be Commanding Officer there.

One of the things that happened, I was coming up on the year-and-a-half mark, I guess, towards it, and I knew I wanted to stay three years there. So I wrote a letter to Jim Zimble, Admiral Zimble, the Surgeon General at the time, and said I thought things were going fairly well. We were having some successes. I thought the place needed the continuity of a CO staying three years and a few things like that, and asked him if I couldn't stay for a third year.

He wrote me back, a handwritten note, which I saved someplace, and he said, "I got your groveling letter." [Laughs]

HERMAN: That sounds like him.

NELSON: And said, "I've not been hearing any terrible things from the Northwest, and we're short of COs," or something about like that. I don't know that he said that. He said, "We'll let you stay a third year."

And I thought, "Great. This is just a wonderful way to end my career." So I was just as pleased as I could be.

And then on the first workday of January of 1990, which I think was the second of January—I'd have to go back and look at the calendar—it was about 7:55 in the morning at Bremerton, and I was getting ready to go . . . I had a morning meeting with some of my leadership folks. I was just picking up my notepad or something to head down the hall to meet with them, and the secretary said, "Admiral [Jeremy] Boorda is on the phone and wants to talk to you."

Vice Admiral Boorda, at that time, was the Chief of Naval Personnel. I had talked to him about several issues. I had talked to him about my concerns about nurses, the difficulty we were having in retaining, promoting nurses, in particular promoting, and some of the issues surrounding that, and I had campaigned for the nurses over some things. And then we had talked about several other things earlier, and I thought, "Well, okay, maybe he's just wanting to beat on me about that a little bit."

But what it was, he called to tell me that I was a selectee for a flag, and it kind of shocked me. So that changed the course of my career.

HERMAN: [Laughs] So much for retiring in Bremerton.

NELSON: Yes. Well, it was kind of funny. He called me and told me that Fred Sanford was also selected. Fred was senior to me in lineal number. So I thought, "Well, gosh, I've got to think about this a little bit."

And then a couple of days after that, I got a letter from Admiral Boorda, just an exceptionally nice letter, and it said, "As a new flag select, I want you to know how concerned we are about knowing what the issues are with you and your family and your career and what your needs are, and if you have special needs, we would want to be sure in our detailing that we meet those and we take all that in consideration."

I thought, "Man, that is such a nice letter and so concerned and willing to work with us." I said, "I've never had this before. I've always been told what to do."

Well, the day after I got that letter, Admiral Boorda called me again, and he said, "You probably got a letter from me."

I said, "Yes. It was a great letter."

He said, "Forget the damn letter. I want to tell you where you're going." [Laughter] And so there started my detailing as a flag officer. So it was kind of what I was used to.

HERMAN: You were much relieved, probably. At least you could deal with this.

NELSON: [Laughs] He said, "You're going to go to Atlantic Fleet to be a Fleet Surgeon, and also with additional duty orders to Atlantic Command and SACLANT. Anyway, we talked about that just a little bit, and I said, "Well, if you aren't going to let me be your next SG (which I knew was coming up that summer), I . . .

[Begin Tape 2, Side 2]

NELSON: Anyway, I said, "If you aren't going to let me be the next SG, then this is the next best job in the Navy." I really was trying to be a little tongue-in-cheek, but, you know, you throw your aura out there wherever.

Well, he was flabbergasted that I'd suggest such a thing, and I was delighted to go off to Atlantic Fleet. This was still early January, and they wanted me there in February. I convinced them that that was a bad time, since a war was . . . actually, the war had not even gotten under way when this was starting, but we were posed for that. I think the war started on January 16. I convinced them to let me stay a little bit longer, and I detached then in late March from CO of Bremerton and reported in to Atlantic Fleet early April, about April 10. Before that, I'd gone down and visited Atlantic Fleet and met Paul David Miller, Admiral Miller, who had just reported in himself as Atlantic Fleet Commander-in-Chief, and I really liked him. We hit it off really well.

But there were a couple of things that I remember. Admiral [Frank] Kelso was the CNO when I was selected, and he brought new flag selects. Altogether, there were about forty of us then. This was line and staff corps as well. He brought us together for a week's new flag knife-and-fork school, and our spouses. It was a very good week, and I met a lot of people, met some I already knew from the line and from staff corps, but met a bunch of others and became friends with them and their wives, Alice and I did.

Admiral Kelso said something that I thought at the time, "Ah, that's not likely." He said, "Many of you are going to work together for the next five or six years. Some of you will be eight and ten years. Some of you will work with each other for as long as the next fifteen years."

I thought, "I'm going to be long gone well before that."

Well, that was eleven years ago. [Laughter] There are still five out of my new flag class, new flag group, who were in that. There's the current CNO, Vern [Vernon E.] Clark. Vern and Connie were part of that. Naval Reactor's currently N8 is Admiral Skip Bowman. Skip and Linda were part of our class. And then Vice Admiral Art [Arthur K. Cebrowski] and Vice Admiral John Ryan were of that same group.

HERMAN: So he was right.

NELSON: He was right. And probably two of that group will hit the fifteen-year mark, I think. The CNO will come very close to that, if not hit it, and so will Skip Bowman, because I think he's started the second four of his eight-year tenure as N8. So Admiral Kelso was right. [Laughs] And I will have hit almost eleven and a half by the time I retire. So it was a little more prophetic than I realized.

Bremerton, I hated to go. You know, nineteen months there. I really felt like I'd been cheated, because the command was making great movement. We had done well with our folks during deployment. They had performed well. They were coming home. I got to meet some of them just a day or two, go to the airport or wherever they were coming back through and meet them and welcome them back; and they went on leave, and many of them I never got to see again, and some I never got to see on their way back. And then we held a change of command on the former USS *Wasp*, one of the few times a staff b____ got to hold a change of command on board a ship. [Laughs]

Then Alice and I headed back to Norfolk. I was treated extremely well by Admiral Miller, Paul David Miller. He chose, even though I was a captain—I had not yet been promoted, and the job would not allow me to be frocked because my primary was with Fleet instead of the Joint job. He put us on Dillingham, living on Dillingham, which is Admirals Row, and that started a few people that, even though I was a flag select, I got to live on Admirals Row. [Laughter]

HERMAN: Life can be sweet sometimes.

NELSON: Yes. Well, anyway, I got promoted during the time there. But we had a wonderful time. I enjoyed the work. I had three staffs, three jobs, and I had a lot of fun at it.

The first job with Atlantic Fleet, I got to get back to sea a little bit and got to see what was going on with the fleet, got to influence how we were doing health care there and how we were doing oversight of it. I was able to bring the process of privileging providers and how we handled credentialing of providers in the fleet into a single system that I believe is how they're doing it still, probably with some of the same people. But we brought it together and handled it every bit as well as it's done ashore, so that we knew the quality of provider and oversight that we had with our fleet physicians. So that was very rewarding to work with the type command medical officers and, through them, with the operational forces on the medical side. Also got to influence it from how the line was looking at things.

Now, also with that fleet job, since the hospitals then worked for their RLCs, Responsible Line Commanders, which is what we'd done in '89, those RLCs worked for the fleet. So my boss was the boss of all the hospitals that were part of the Atlantic Fleet. I visited all those hospital on his behalf and visited those RLCs and started influencing how they worked together, and we actually held the first of what's now, I think, an annual affair. We held the first two of the . . . had the fleet, medical leadership, and the COs of all the hospitals and clinics that had COs, and held a conference. Actually, both times had the Commander-in-Chief of the Atlantic Fleet come and talk to them about how he saw us doing business.

But the idea was that we started trying to get some uniformity about how our RLCs were looking at their hospitals and clinics and how the oversight was, and then we really did put the Fleet Commander in charge of that so that we had some sense of how well our facilities were supporting the fleet and the operational forces. Not everybody's looked at the job being that way, and it hasn't always been uniform and stayed that way. But we felt it was important, and I had support of the boss to do that.

So I had a great time at Atlantic Fleet and felt good about some of the progress we made there.

The Atlantic Command job got very interesting about November of 1990 because of the turmoil in Haiti, and the Haitians started going to sea, putting to sea. We started picking them up, and we had a whole bunch of them put aboard the LSD [USS *Tortuga*]. That was one of the Whidbey Island-class ships. It had a great big well deck on her and had all these folks that had been picked up at sea in the well deck. The ship pulled into Guantanamo Bay, and it became a big decision on the part of the State Department and INS and others, with also Atlantic Command involved—Admiral Bud [Leon A.] Edney was the boss there at the time—what do we do with all these Haitians?

Well, as you know, they went through the whole process of making decisions to put them ashore and eventually calling them migrants, and then we went through a real evolution of how you house them, how you provide health care for them, sanitation, the whole thing. So I was involved and went down to Cuba several times to visit over that. A very interesting process, very educational for me. It also was the first time that I dealt with really trying to put together an operating joint medical treatment facility.

HERMAN: There was a camp that was built there.

NELSON: Yes. We had the existing hospital, which was not configured adequately to take care of this many migrants and their health care needs, so we took care of some there that needed that kind of admission, but most of them we handled in a makeshift hospital we put together and some clinics that we put together in the camps.

We initially had two camps. And we staffed that rather than just taking it all out of one service, we took some staffing from different pieces of the three medical services, and that worked well, except on the enlisted side. I think if I learned anything out of that, it was, don't try to mix your enlisted. That didn't work very well, and we had to reconfigure after that. But rather than strip one service of that much asset, we rotated it for some time. Or, I mean, mixed it. And it was educational for all of us.

That was a very interesting time. That took a fair amount of attention. And that went on for all of my time, pretty much, in that job.

HERMAN: That was only the second part of the three jobs. That was the second job. You had another one.

NELSON: SACLANT. I was the Medical Adviser, I think it was called, to Supreme Allied Commander of Atlantic, which is a NATO job. And so I ended up, when I went there it was one of three major military commands in NATO. You had two that were located in Europe and one in North America. While I was there, one of the two in Europe got rolled into the others, and you ended up with just two major military commands.

That was an interesting job, because you found yourself working with your counterparts in Europe. I didn't do near as much traveling as some have in that job and I didn't do as much as my NATO folks would have liked me to, but I did as much as my other two hats would tolerate. I went to Brussels a fair number of times, went to Norway, went various places in Europe, working medical issues of NATO. Had a lot of fun at that.

Alice and I really had a lot of fun getting involved with the NATO folks, from a social

standpoint and from just an exchange standpoint, an exciting group to work with and get to know, and I still have friends in that group. In fact, my Royal Navy Surgeon Rear Admiral, Mike Payne [phonetic] has retired to Vermont. Let's see. No, he's near the border of Vermont, but he's in New Hampshire, and is teaching biology in a boys' school up there. He retired from the Royal Navy now.

HERMAN: That's very unusual.

NELSON: [Laughs] Yes. Well, his wife is an American citizen. Anyway, we had great fun together. But I got to know a lot of the line folks in the European military forces, as well. We thoroughly enjoyed that. That was a wonderful combination of being on three staffs, getting to know three groups of people, work with three groups, but also socialize with three groups, was kind of a, probably in some ways, a social highlight for Alice and I of our time.

But I got to participate in a number of the conferences that would be held, NATO conferences, where the big boys would be kind of plotting the future, and I got to be a fly on the wall that watched all this. And so it was a personal pleasure for me when the CNO couldn't attend some of the ceremonies, the official ceremonies of the fiftieth—I guess it's fiftieth—anniversary of NATO that were held here in town, and I was the stand-in. I'm sure it was just a roll of the dice. The three-stars regularly stand in for the CNO in different functions, and it's usually who can't escape from it that gets it.

HERMAN: So you were the one star that couldn't escape.

NELSON: Oh, no, I was a three-star. I'm sorry, I'm getting ahead of the story. That's since I've been SG. See, that happened just a year and a half ago or so. I'm getting ahead of the story. Anyway, I got to be the guy who represented the CNO at the big ceremonies where you had the heads of all these NATO countries. There was Bill Clinton. All of the heads of these NATO countries came and spoke, brief speeches because there's so many of them, at the NATO ceremony here in town. I thoroughly enjoyed it.

HERMAN: This is a heady experience for a kid from Oklahoma.

NELSON: Well, it's certainly different. [Laughs] Anyway, I got ahead of myself.

I was in those three jobs until I got a call in the spring of '93, early spring. I was in a meeting that Atlantic Fleet was holding just of our flags. I've forgotten exactly the occasion. It was kind of a cold, early spring day, and we were out at Dam Neck on the beach holding this meeting, and I got a note passed to me that Surgeon General Don Hagan wanted to talk to me. So when there was a break in the meeting, I went out and called Don, not having any idea in the world what it was about.

He had asked us earlier for what our wish list was, where would we like to go, what sort of job would we like next. I had not exactly said a specific job, although I kind of knew what I'd like to have, but I didn't want to say, "Well, the only job I want is such and such." But I made it so that that was how it narrowed down, without saying it. I had filled out the wish list and said, "I like command much better than staff job. I prefer a command job. I prefer the West Coast,

the Pacific, over the East Coast. I'd like to command a medical center. I've commanded a hospital and various things."
HERMAN: [Laughs] I like the way you're narrowing this down.

NELSON: Well, I knew that Fred Sanford had asked for Oakland, and the other coming open was San Diego. No, it wasn't scheduled to come open, but the other possibility was San Diego. So I had sort of focused it down, but I didn't think that was likely. I thought maybe he'd leave me another year at Atlantic Fleet, which was fine with me. But I'd at least let him know what my wishes were, and I knew that Fred was already promised Oakland. Dick [Richard I.] Ridenour had only been a year at San Diego, so I thought it wasn't likely he'd pull him out.

When I called Don back, he said, "I'd like you to go to San Diego." [Laughter]

I thought, "Okay. Well, what's happening to Dick?"

"Well, don't you worry."

He was going to bring Dick to be his Deputy, Dick Ridenour, and so he was breaking him out of there at fourteen months to go be his Deputy. He had been his Deputy once before when he'd been at Bethesda. So Dick Ridenour's poor outcome was my great outcome. So Alice and I went to San Diego and turned over on, I think it was, something like August 7, 1993, Dick Ridenour, and that became probably the best tour of my career, my life.

HERMAN: That's the plum. Of all the hospitals, that's got to be it.

NELSON: You know, of DoD it is. If you look at the hospitals in the military in the world, and I've been to a lot of them, that was the plum at the time. It is the busiest. When I went there, it was kind of neck and neck with Wilford Hall as to performance, but we became a busier tertiary-care hospital than Wilford Hall over that next several years.

I went there with two-year orders, and before it was over, I'd milked it for five. [Laughs] I think part of it was, nobody wanted to see me back in Washington, which I was happy of. Turned out, there was only one person who had the job longer than myself, and that was—his name's Horace—.

HERMAN: Warden.

NELSON: Red Warden. Admiral Warden had been the Commander there at Balboa from 1964, sometime in '64, to in 1972. He had been there seven and a half years. I ended up with five, and I think the next nearest person was four or something. I told him, after I'd been there a while, that my goal was to beat his record, because Admiral Warden still lives out there. He's one of our patients, and I used to kid with him a lot.

But Admiral Warden knew how to get even with me. He would always ask me, he said, "Now, tell me how much help you have?" What he meant was, how much personal help. Well, basically, I had an administrative assistant, secretary, girl Friday almost. I hate to say girl, whatever, there. But Donna McKenzie, who had been the secretary/administrative assistant to the Commander there for several years, was my only assistant. I did not have a separate EA. I did not have an aide, didn't have a dedicated driver, didn't have any messmen, didn't have a gardener, all these things. He loved to tell me about how much help he had.

HERMAN: I'm going to stop it here, because we've been going for——
[End of Interview]

Interview with Vice Admiral Richard Nelson, Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery, August 1, 2001.

[Begin Tape 3, Side 1]

NELSON: We were in San Diego.

HERMAN: You had just arrived in San Diego, and you had had this discussion, this banter, if you will, with Admiral Warden.

NELSON: Red Warden.

HERMAN: He said, "How many servants do you have?" You were explaining that, how you had told him you didn't have a mess steward, you didn't have a driver, you kind of were on your own, and he kind of chuckled over that.

NELSON: We got through all that, though.

HERMAN: We got through that part of it, but we didn't really discuss your tenure there and some of the issues that you dealt with at San Diego.
NELSON: That was my first tour of San Diego. I had never been stationed there before. I had wanted to be, and I'd visited there a number of times in different capacities, but had not been a part of that command or that community. I think I mentioned earlier kind of how I ended up there.

When I went to San Diego we were starting to stand up lead agents for the military health system. It wasn't in my orders that sent me there, but it was in my verbal orders, I guess, to be the Lead Agent for the TRICARE Region 9, Southern California. So it was really two jobs, and the one as Lead Agent was really a brand-new job and nothing had been done to start that until we got there. I guess turnover there was in August, and later that same month I met with the commanders of the Army and Air Force facilities in that region, as well as the Navy, and we started on a journey to really work together and to do things together.

That became a very interesting and, I guess, pleasing experience for me. The first meeting that I held with these guys, Ed Martin, you'll remember Dr. Ed Martin was the acting Assistant Secretary of Defense of Health Affairs at that time. Ed attended, because we were also going through some contract issues and changes with our managed care support contract. Ed was there, as well. But it was interesting because you'd look around the room when you take a break, here would be Navy guys standing over here in one corner and here's the Army over here and here's the Air Force, and there's no mixing. I thought, "Boy, this is going to be an uphill battle." And it was for the first several months, just because everybody had their own little empire, and they all liked it that way and wanted to be left alone, except when they needed

something. So my task was to kind of bring them together.

Fortunately, I had the biggest set of assets with Balboa being kind of the big bird in that region. I guess my attack at it was not to play the flag officer, because I was the only one that was a flag officer, but rather find out what— [Tape interruption.] Part of what brought folks around and helped us really get moving was they learned that I was willing to share the assets that I had and I saw part of my responsibility was to make the whole region run as efficiently as we could and meet their needs, not just Navy's needs. It didn't take too long to actually develop a level for us that really made the color of the uniform go away, and that was five years of association with the commanders of the hospitals and clinics in that region. That was very satisfying to me.

And we really made a difference. We became the region that was recognized as the most functional. We returned the most money to MHS, the Military Health System, from contracts. We were able to draw such a large number of patients back into our own facilities that our bid price adjustments on the contracts always returned oftentimes, I think, over, gosh, what was it, two and a half, three-year period there at one point, we brought back in $180 million. It was not unusual to bring—I think the bid price adjustment that occurred at the end of my time there, or covered the time period to the end of that, brought in about $40 million for one year, but other years originally had been even better than that. So we really, between us, and working with our contractor, which we made a good partnership with, we were able to improve our delivery of health care in that region fairly dramatically.

Now, I was always kind of caught between two things, though, in helping do that. Balboa during that time became not just Navy's, but DOD's busiest medical center. We had the most inpatients and the most outpatients across DOD during, I guess, the last three years I was there. We outstripped Wilford Hall, which was the Air Force's, which was always the big competitor, and Portsmouth, which is the Navy's. Right now, Portsmouth actually last year overtook San Diego. But at the time, we became the biggest.

Now, what that does is, once you get that kind of efficiency in an organization, the staff that runs that part of the organization doesn't want to share resources with anybody else, because they've taken all the resources to accomplish the work that they've picked up. So I was always having to explain to my staff why I was loaning Weed Army Hospital up at Fort Irwin an OB-GYN doc for three months, which had the potential to hurt us at Balboa. So I was always kind of caught in the middle a little bit of seeing that I was covering the whole region and trying to keep from hurting Balboa out of it, and I think we were able to do that pretty well.

HERMAN: How was the relationship at that time, being that that was really the biggest—of course, Norfolk's the biggest, but certainly on the West Coast that's pretty busy Navy-wise, as far as the fleet is concerned. How did all that relate to your responsibilities to supporting the line and the fleet?

NELSON: Well, it worked fine. I mean, San Diego is the biggest home for the Pacific Fleet. The Pacific Fleet is split a little bit more than the Atlantic in some ways, but that's the big site and the home of both the air- and surface-type commanders.

One of the things that's always been important to me was the relationship with the operational forces. When I got to San Diego, I was concerned that we weren't viewing that

responsibility as broadly as we should have. We had a chief responsible for fleet liaison, and what that amounted to was, if the fleet called him up, he would help them make appointments. But we didn't reach out to the fleet, really, and so we intentionally changed that. I've always been of the opinion that the cheapest goodwill, and not just goodwill, but the cheapest thing we can do to advance health care for our customers, our patients, the fleet, is to really have a good fleet liaison approach to things, and one of the things I just signed last week was a new—actually, we have not had for a few years a fleet liaison—Fleet/Marine Force Liaison instruction, and we now have one that defines what our expectations are to everybody on that. But all that's getting off.

I put a Medical Corps Officer in charge of fleet liaison. I gave him fleet-experienced enlisted staff, including a master chief, to assist him, and we reached out to the fleet. We said, "We'll help you not only with getting appointments in our facility, but we will back you up with manning where you have a shortfall, we'll help you with quality control if you need that, we'll help you with equipment repair, and whatever you need that might be health related, let us know. And if your family members are having problems or something with access or whatever, come to us first." I'll tell you, once we did that and got that in place, and these guys would go out and visit the ships and they would go talk to the XO, talk to the senior medical department representative, I never got another complaint from the fleet.

One of the things I enjoyed most about San Diego was the relationship with the line and the other staff corps represented there. We still have a lot of friends who served there with us. Some are here in town, some are retired. Most are retired now. But we still get together with them regularly. In fact, about a dozen of them are coming to the retirement next week from all around the country, many of them big shots in industrial organizations now. That was a wonderful time for Alice and I, to have the association with the line and be accepted as a part of it.

The fleet commanders that we had while I was Commander of Balboa, the Pacific Fleet Commander-in-Chief, Admiral [Ronald J.] Zlatoper became that after I'd been there less than a year, and then he was followed by Admiral Archie Clemins, who was there until I left. Those two really made us feel a part of the fleet. They included me in their flight conferences and meetings which they would hold several times a year, and Alice and I would participate in those all around the—wherever he was holding them. We got included, and that was important for Balboa and Navy Medicine there because we could influence what was happening and how they were thinking about issues. I still have a good relationship with most of those folks, including Admiral Clemins came by to see me recently. He's retired now. But we focused on serving the fleet.

HERMAN: What were some of the issues that you dealt with at that time, during the early time you were at Balboa?

NELSON: Well, one of the things, I never lose sight of what our primary mission is and what we're here for, and that's to be prepared for contingency, whether that's war or something less than war, not only to be clinically prepared, but to have our people prepared with the right training for the platforms that they're going to be aboard. But another part of that is also to see that we have done the right things to prepare the sailors and Marines for that, from a health

standpoint, whether that's health promotion or prevention or just overall medical readiness.

But that was not a big issue while I was at Balboa. I mean, we kept our eye on that. We did the training. We really got that down good. But there were some other things that really kept our attention, and probably the biggest single one, and it's the one that has been the focus of too much of my time—I don't want to say too much, but an inordinate amount of my time in this job has been dealing with peacetime health care issues.

When I got there and I took a look at our statistics, which we haven't always been very good at keeping good data, data quality hasn't always been good. But when I took a look, we let too many of our patients be seen in the private sector. At that time, we had CHAMPUS reform initiative in California, and too many of our patients, we were paying for them to be seen downtown when, if we paid attention to our own inefficiencies, we could have brought more of them in-house. So that was the biggest, probably, single thing that we worked on during my five years there was to look at what made us inefficient, and there was a lot of reason behind this.

One of the things that I did shortly after getting there, I spent a lot of time talking to the staff, but I also put out, after I'd been there just a few months, I waited a few months, but I put out a piece of paper to the staff that really talked about what my expectations were, what my view of us as an organization was, and where I thought we needed to concentrate on going. And then that sort of became the vision, the road map to where we needed to go. The staff really took that on, but it took several months to get them oriented and moving in that direction.

One of the problems that I had early on was a dysfunctional executive steering group, which surprised me. I don't know how much of that was the turnover or what. My predecessor had only been there fourteen months, so within less than two years, they had had three different commanders in the place, and I think some of them were just waiting to see how quick I'd leave. [Laughs] I surprised them.

HERMAN: They were in for a surprise.

NELSON: Part of what I put out to them was that I expected to be their commander there for several years. Even I didn't have any idea what that really meant. [Laughs]

HERMAN: You were really bluffing at that point.

NELSON: [Laughs] Yes. Part of what I told them was, we were in a competition with the private sector for those patients, and they really were our patients to give up, and we needed to not be timid about our work at bringing those patients back and making them want to come back.

Our graduate medical education was dependent upon that. Not only was it the right thing to do for the patients, but we needed it because Balboa is the biggest trainer in Navy Medicine, more residents and interns and other kinds of training, psychologists and nurse-anesthetists, PAs, a whole variety. We're the clinical base for a lot of that, as well as the regular residencies and some of the fellowships. I made a point that bothered a lot of the staff at the time, but I said, "Our first priority is to take care of the patients, and graduate medical education is secondary to the requirements of the Navy for taking care of the patients. We train to what the Navy's needs are, not to what our desire is to train."

That made people nervous at first that I was against GME, which I'm not, I'm a strong

supporter of. But it has to be focused on what our requirements are. We actually were able to strengthen our GME programs, because we were able to bring a larger volume of patients back in. Part of a function of a—if you want good cases, part of it is, if you bring a higher volume of primary-care patients through, you're going to bring with that a certain number that need the cardiologists, they need the otolaryngologist, the neurosurgeon, the CT surgeon, everything. So a lot of our effort was to make ourselves more efficient, and also more customer-friendly.

One of the things that they had done just before I got there that they were so proud of and I pulled my hair out about was they did away with central appointing and drove all appointing back to the clinics, individual clinics. That's an inefficient and sometimes a very wasteful way of handling patients. You can do it centrally. I don't mean centrally like we do it elsewhere, where a place in Baltimore handles all of the Northeast. I hate that sort of thing. But within Balboa, we eventually started handling most all of the primary care appointing in one place, and I think you should be able to do that on a larger scale. I never got as far as I wanted to with that at Balboa. But you had to look at not only efficiencies, but what gave better access to the patients and were pleasing to the patients.

One big issue when I got there, everybody was calling Balboa "our new hospital," and it was five years old, I think, at the time I got there, a little over five. Going on six years old, it must have been. Before I ever checked in, I drove around the compound, walked around it some, before I even went to the front office to say I was aboard. There were weeds grown up around the place. There was bare ground in places, which—they'd had a drought for a number of years, but it had been over for six months before I got there. One of the funny stories that the staff tells on me now—they learned to laugh with me about some of it. I'm sure they just laughed at me initially. I'd walk around, and it's a beautiful campus—it should be—and a nice facility, well laid out, to be pleasant, anyway. It has a nice courtyard, and it's all brick and concrete.

HERMAN: Stucco.

NELSON: Yes. Yes. Stucco on the buildings, but the courtyard is very little grass. A few trees in it. But I'd walk around, and it looked like all over the place were all these spots that looked like tar, looked like tar to me, and I wondered where in the world? Have they redone the roofs? Why is all this tar around here? And once I got to asking the questions of facilities people, I figured out this was gum.

HERMAN: Gum?

NELSON: Gum! At the time, we still had a corps school there at NSHS (Naval School of Health Sciences), right next to us on part of the campus, and the kids did their clinical training in the hospital. And they sold lots of gum, and they just spit the gum out wherever they walked.

Well, I asked about steam cleaners, and everybody looked at me funny. They didn't know what steam cleaners were. So we got some steam cleaners, and we got some new equipment to clean the compound with, and we started dressing up the plantings around the place and started stopping some of the shortcuts people were taking, or else making them a permanent walk—we did some of both—to spruce the place up. Because one of the things that patients

make decisions about quality of care on, they don't always know how to judge the doctor, other than whether he's in a good mood or not, but they get a sense of what you feel about yourself when they come aboard the compound and see how it looks. And so I'm proud to say, probably the best-looking compound we have in Navy Medicine now is Balboa. That is a beautiful compound. We even went so far—I got a senior chief—in fact, she made senior chief after I went there—, who had the responsibility of oversight. She's the one I worked with on the clean-the-place-up sort of stuff. She had the housekeeping staff work for her and the folks who did the outside stuff work for her, and then we had a contract, which we put a hot stick to, on maintenance of the shrubbery and the grass and the like.

One of the things we had was old benches that had been brought over from the other hospital, because nobody planned for any outside seating for folks. It's Southern California, you've got to have outside seating for folks. If you're waiting for appointments or waiting for your family member or whatever, you don't want to sit around inside or stand around inside. You want to sit in the courtyard and wait on them. Well, they had all this lousy-looking stuff out there, some of it busted up. It didn't match or anything. And so I asked her to look and see what the possibilities were, and she found a place that would make us some really nice-looking—one of the things, it had to be something that was sailor-proof. She found a place that would make us some nice concrete seating. It looks like a sofa, almost, but an outside bench with backs and arms and everything. And they put our logo—we had a new command logo, this very pretty logo—they put that into the back of it in color, so it had the color of our command. And those have been in place out there now seven and a half years, and they still look good. We put those all around the compound in the places where people might gather.

So one of the things I was proud of was changing the appearance of the place, and we didn't break the bank doing that. But at the same time, we worked on the inside of the facility to make it more efficient, because the practice of medicine, of course, changes regularly. And one of the things we were in a big change was changing from being so focused on inpatient. We didn't lose that focus. In fact, we increased our number of inpatients. But we had to start concentrating on the outpatient side of it in a bigger number. In fact, we raised our outpatient numbers almost over 40 percent over about a three-year period, the number of the volume of outpatients we were taking care of in that command.

So to do that, you have to work at the things that will make your practitioners more efficient, as well as make it pleasing to your patients. So you look for the things that will decrease your wait time, that will increase the exam rooms for your practitioners, those sorts of things. You don't have a stretcher to stretch the facility, so you have to stretch the hours that you're open or how you do things. Then you have to coordinate how you run ORs or how you develop outpatient ORs for minor surgeries in some of the clinics. So there was a lot of effort. It was a vision that I helped the staff understand and develop, but it really was the quality of staff that we had that made all these things happen. They started really working at it. At the end of a year there, we had reshaped the Executive Steering Council to be one that was really running the business of that organization and running its direction, and it developed a strategic plan and vision and all that really put a fire under that place.

One of the things we recognized was that if we were going to capture more of the ambulatory patient population, we were going to have to get better organized on our primary care side of what we did. And so one of the things we did was, we'd just built a brand-new, beautiful

clinic, a big one, on the Naval Training Center site there in San Diego to serve the training center. Of course, by the time we opened that thing, we were closing the recruit training center, and they were going to turn all that back to the city, which they have now done, turned almost everything back, but we still own the clinic. I went to our responsible line commander at the time who was dealing with the city on how we consider turning things over, and I said, "We've got to retain this clinic. I need a clinic in that part of town. I need it for reasons other than the recruits."

What we ended up doing was keeping that beautiful clinic and even taking the dental part of that clinic and converting it, because the dentist didn't need a place there because they take care of only active duty, and active duty went away from that part of town. We converted that into exam rooms and created a big primary care clinic there and brought in family practice docs to staff it, uniformed family practice docs. So we became the first of the big three to really—I guess Portsmouth had tried it and gotten killed on doing a family practice residency training program. We didn't try to create that, because I knew that would compete and be in trouble with the other training programs. But we brought in experienced family physicians, about nine of them as I recall, and started this primary care clinic. It became the most popular primary care clinic in our system out there. We included some internists in it, and it was a part of town where we needed the support.

One of the things I was proud of was how we really got all of our primary care kind of coming under one set of rules and one oversight and all focused on a comparable care of the patient, but seeing that those patients then were directed back in, for their tertiary care, back into Balboa, and their specialty care.

HERMAN: Is that clinic near Rosecrans, off that area?

NELSON: Yes. The base sort of was on Rosecrans and Nimitz.
HERMAN: Where the old NTC, right on those grounds?

NELSON: Yes. If you go by there now—I was by there just last month—they are tearing down the old recruit training facilities, many of them. Actually, there's going to be some housing built in there, either condo kind of housing or townhouse kind of housing built to house Navy folks, but also there's going to be hotels and all sorts of things that the city has planned to go in there. They've got their plans started now.

But we've been able to retain that clinic, and it's in a location so it serves the Navy that's out on Point Loma. We still got a sub base out there. That's another thing we did. We moved our substance abuse rehabilitation center and some of our training for that out to the submarine base. We were able to take a nice structure out there and do some renovation and move it, and that created more space in Balboa for other functions.

The folks that are out at the submarine base or come in there off of ships, also those on the top of Point Loma—there's a variety of research and other organizations up there—those flow to that clinic now that we have at the old NTC. And there are a lot of our family and retiree beneficiaries who live in that part of town and use that clinic. So it's a great site and a nice facility.

There was always something going on, some opportunity to improve how we did

business. But one of the things I saw there, one of the things that helped me, really, in a lot of ways in our attempt to change how we did business was, I could point out to the staff what was going on in the private sector. It was easy to look across the fence and see that the private sector in California, and there in Southern California, was really into what was managed care. There were all sorts of competition going on, and part of that competition was aimed at trying to capture our patients. So it was easy for our folks to start to see that there really was a competition and that we had to be preferred by the patients, because the patients had choices.

Some of the things that I got great satisfaction out of were the patients who would want to come by and stop in to see me to tell me that they had been getting their care on the outside, and they'd come back to us; and after having come back, much preferred to stay with us, because we treated them better.

Balboa, I went through two JCAHOs (Joint Commission on Accreditation of Healthcare Organizations) while I was there, the first one after I'd been there two years and the last one the month that I departed from there. We got a 95 with commendation on the first go-around, which we thought was a wonderful score and the commendation was very good; and the last one, we got a 99 with commendation.

HERMAN: You can't get much better than that.

NELSON: Well, the 99 occurred, the drop of one point was primarily because on the fifth deck of our nursing tower, there's a stairwell that went up to the roof, and you're supposed to have a sign up or a chain across that says "not an exit," and somebody had taken it down. [Laughter]

For one thing, the staff felt so good about their performance and the outcome of that JCAHO that it was a real upper. In fact, both of them were for us. But what I was getting at is, recently, here in the last six months, I guess, somebody sent me a copy of an article out of the local San Diego paper. They had done a report on the local health care facilities—hospitals, primarily. And part of what they did was report the JCAHO scores of all the local hospitals, and very pointedly pointed out that Balboa led by far.

HERMAN: That was a legacy. You left a legacy behind.

NELSON: I was very proud of the staff over that. They took a lot of pride in being the best.

But it also showed up in other ways. The training programs always had great outcomes on the board scores for in-service testing that was done on residents and the board pass rates and the scoring. Nationally, it became common for them to be if not in the top 1 percent, at least in the top 5 percent in the nation on the training programs and their outcomes. So our GME programs stayed pretty strong. In fact, got stronger during the time that they were actually getting more work through there.

I got eventually to where I was worrying that some of the staff was—doctors, when you give them tools to be doctors and take care of patients and you support them right, which we never got at all perfect by any means, but when you do that, they love to see patients, and they love to be doctors, and they'll work themselves to death if you don't watch them. So anyway, I felt very good about that.

We didn't have any big crises. I mean, there's always something going on. We sent our fleet hospital off to Bosnia for six months, and that, of course, is disruptive because it takes away a lot of your talent. I had four different Deputies while I was out there, part of it because of the Bosnian thing. But we became very adept at dealing with those things. We gained responsibility for the *Mercy* while I was there and switched from fleet hospital to the *Mercy*. Well, the *Mercy*, we were already partially supporting the *Mercy* when she was up in San Francisco Bay, but when Oak Knoll closed, we gained responsibility, and we eventually moved the *Mercy* down.

But one of the things we got good at was calculating what the costs of the different things that we did were. What was it going to cost us when the ship put to sea and we had people aboard for training? One of the pieces of paper that I've left for my relief deals with our review of what Graduate Medical Education costs. We figured out what it costs us to train the interns and residents. I don't know if anybody's ever done that before, but I thought it was important that we know, because if somebody wanted to challenge us over buying that training in the sector private versus doing it ourself, we needed to know really what it cost us, and then, on the other hand, what was the value of it. We didn't get it perfect, but we got a good sense of that.

But we also got enough of a good sense of what it cost us when the *Mercy* or any of the other platforms that we supported took our folks for an extended period for training. I always supported the idea that it was important that we train, but we train to what the requirement was and that we not waste people's time away from the command doing that. That became a big issue, and it kind of came to a head over the Colonel Blitz exercise that occurred, the first time it occurred after we gained responsibility for the *Mercy*. The exercise was held off of Pendleton. A lot of it was amphibious exercise, with the *Mercy* offshore, and it involved some of our folks ashore. We had a fleet hospital set up there, but also a lot of folks with the Marines. A whole big exercise. We had a whole lot of people out of Balboa to support it.

The plan that was put forth by the planners was that I was to send something like 600 people up to Oakland to go aboard the *Mercy* to ride her down to San Diego for the exercise, and it was going to take about five days by the time they left us, went aboard the ship, then transited from San Francisco Bay down to the exercise, which was just north of San Diego. It was going to be five or six days of dead time in there, basically, for our people. And when it was over, the ship was going to pull in and be homeported in San Diego anyway. They had her lined up for dock at the submarine base out at, or into Point Loma.

So I got my folks to figure out what was that going to cost us and what training was in there and what time was there for training, so we got to look at the whole picture for this. I went back to the planners and said, "We're going to do it differently." I didn't own the planners, but I could influence them. I said, "Why don't you figure out how to plan to bring that ship in. Don't do anything more than bring her to the pier at Point Loma, at Ballast Point, at the submarine base." It's just right at the mouth of San Diego Bay, so you're really still right at the ocean. I said, "Bring her in there. Put no more lines over than are required to keep her stationary long enough, and we'll load our people. And then you can put back to sea and start their exercise."

Well, they hemmed and hawed, but when I told them what the cost was for me of that time, they started to understand where I was coming from. It was going to cost me $940,000 or $960,000. Either I was going to contract out or I was going to have to do various things to overcome. It was going to cost me that much money for the time that was going to be wasted

with that exercise.

HERMAN: And travel time up there.

NELSON: Well, that's part of it, when you figured all that out. Well, they figured out that it was actually a lot cheaper to dock that ship for a couple hours rather than do that, and that became a part of our planning for any evolution. If it was map training with the Marines or whatever, don't waste my people's time. We have to train and we need to train and we have to have the right training, but don't waste a surgeon's time sitting around on his hands when he'd like to be using them.

So we really got more of a business sense. The best business practices are also oftentimes the best clinical practices. I convinced people that we weren't trying to manage people's care so much as we were trying to manage their health. You don't hear me talk about managed care. You hear me say managed health. By that, I mean what we're trying to do is manage people to stay as healthy as they can be. If they get a disease, then do disease management to keep them as healthy as they can be. Managed care's gotten a bad rap because people look at it as how you manage to deny access to people, keep them out of facilities. Well, I still like to keep people out of facilities, but keep them out because—

[Begin Tape 3, Side 2]

HERMAN: San Diego has a special place for you. I mean, this was kind of the ultimate assignment that one could have in the Medical Department was to be the skipper of that hospital, and obviously you enjoyed it thoroughly.

NELSON: I think I told you before, in part of my discussions with Red Warden, I told him that I planned to outlast him, and I was proud to have been the guy that came the closest, anyway, to doing that with five years there.

HERMAN: And then something went wrong.

NELSON: Yes.

HERMAN: [Laughs] What happened?

NELSON: I always tell people that the reason I was able to stay there five years was because they were afraid to have me in Washington, which I think was probably true. But I had run it as far as I could go. I knew that I was going to have to retire then in '98. Let's see, I've got to think about it a minute. Yes. So I had started planning for a November 1, '98 retirement. Alice and I had attended the transition course they put on for flag officers in the Navy. We did that in late October, first of November of '97, so we did it a year ahead. And we went home, and I calculated out where I would be at that point, years in the Navy and all that sort of stuff, and that I had enough to retire as a two-star. I spent all my two-star years at San Diego, entirely. I went there as a one-star, but then became a two-star.

Anyway, we figured all that out. One of my classmates at that—our classmates, this is a

couples transition course—one of the couples there with us was a green two-star at the time, Mike Williams, Mike and Barbara. We obviously were failures in that course, because we both have to take it over. Mike is now the Assistant Commandant of the Marine Corps, he's a four-star. [Laughs] Anyway, we kid. I saw Mike this morning. We met up, we were both going into the Pentagon at the same time. After I took that course, late November I called BuPers, Flag Matters, and said, "I want to check with you and be sure I've got my calculations all right, and I want to give you notice that I'm getting ready to submit my letter for retirement next fall. I just want to be sure before I formally do that I've got it all right."

They went through it with me, and Bob Erskine [phonetic], who I've known for years—we served together at Atlantic Command and SACLANT. Bob said, "Yes, you got everything. You got it figured just right. But the CNO doesn't want your letter right now. We'll still let you out on time if that's what works out, but he doesn't want a letter from you right now."

So we sat around, waiting to see.

HERMAN: That's not a good sign at all.

NELSON: That's right. And as you know, he shortly thereafter called me up and asked me if I would take this job.

It was kind of interesting. I had had an interesting relationship with the CNO, with Jay Johnson. He was a brand-new four-star, brand-new Vice Chief of Naval Operations when Mike Boorda died, and he shortly thereafter became the CNO. I had known him as a one-star, but didn't know him well. We had overlapped in Norfolk a little bit, when he had a battle group there and I was Fleet Surgeon. But shortly after he became CNO, he came to San Diego, he and his wife, Garland, and visited a bunch of commands there, and one of them that they spent hours with was Balboa. Both he and, at a different time, but also shortly after becoming the Secretary of the Navy, John Dalton and Margaret came and spent quite a lot of time with us. When people like that would come and come with their spouse, I'd involve Alice in it, and she would participate. We'd give them a tour and we'd talk to them and show them things, and the staff would get to show off what they did, which was always good.

But he came and spent a lot of time at Balboa, and he always had a lot of interesting medicine, I've got to say that. So we had a great time, got along well. And I, for one reason or another, would see him or talk to him a little bit occasionally. And then we had an issue come up and all. Since I'll be retired by the time anything with this happens, I'll tell you just a little bit of it.

I was the president of a board, selection board for Medical Corps 05. This was back in the spring of '97. That board was a unique board. It was given a selection—we had for years been following the selection rules of DOPMA (Defense Officer Personnel Management Act). Even though we're Medical Corps and exempt from DOPMA, we'd been following the DOPMA rules, which really limit what your selection percentages can be and was limiting 05 selections to about 70, 75 percent, something like that. Well, over the years we'd left an awful lot of extremely good people on the table that hadn't gotten picked up for 05, and so we had above zone some excellent quality, along with what was in zone and even below zone. And so a decision was made to select at 150 percent of what was in zone.

Now, I've sat on lieutenant commander boards that are given select all qualified, which

means 100 percent if you've got all qualified, but I had never sat on one that gave you 150 percent opportunity. So that meant we could go above zone and look for the folks who had been passed over who were fully qualified to be 05 Medical Officers and could pick them up, as well as all qualified in zone. I mean, that was the toughest board I was ever on. [Laughter]

We did that. I had a good group of people, I mean an excellent group on the board members, and we picked what we thought were the right people. But as a part of that, we looked at who were the people who had maybe a single incident that had gotten them to a flag mast or had had several things occur to them that had gotten them to mast, or something had gotten a black mark in their book. When we took a look, none of them were for assault, but they were for doing stupid things, one-time stupid things, which, but for getting caught, many of us had done stupid things. And some of it was for stupid things on the part of the person who took them to mast. I knew personally some of the cases, a little bit about them.

Anyway, all that's to say that we picked half a dozen folks who fit in that category, and one of them had come out of—and they were all people who had owned up to what their issue was, if they thought they were guilty. But one of them had owned up that he had done something dumb. He hadn't assaulted anybody, nothing of that sort, but he had been involved in a minor part of what became a big issue back in the early nineties in the Navy involving Navy Aviation. He happened to be a flight surgeon, and here a few years later it came back to haunt him.

HERMAN: Do I feel a Tailhook coming on here?

NELSON: This young officer, who I later knew past the incident, because he's one of my residents. Well, I can't get into board conduct or anything. I have to stay away from that. But nonetheless, the board selected half a dozen people or so, and that became a contentious issue, and the CNO, I thought he was going to fire me before that was over. I'm proud to say that, I don't know the outcome of all of those half dozen, but I've run onto at least three of them who've been promoted. It took a while. A couple of them only occurred since I've been SG, that I know of.

HERMAN: They worked off those black marks.

NELSON: Yes. But they have gotten promoted because of that board.

On the other hand, we also gave them a list of names of people that we thought should show cause, we thought should be thrown out. So we weren't a bunch of softies. We gave them a list of people to throw out of our Navy, too, that we didn't need in our Medical Corps. I don't know what became of that list. You never carry anything out of there, the names or anything. I just have happened to have run into some of the folks, because I knew their names or I knew them before going into the board, even, or knew them afterwards.

That was an interesting time that didn't endear me to the CNO, but some of the outcome of that, in the longer run, caused us to engage again. And we never, ever—I communicated with him about that issue once, shortly after the board, but that issue we didn't discuss anymore. But he called me up and asked me to be SG, and we went through the process, you know. I interviewed with the Secretary and with him, a formal interview with him, as well, and that's how I screwed up on getting retired in '98.

HERMAN: The story of your life, right?

NELSON: You know, if I'd had my druthers, I'd have stayed at Balboa another three or five years or something.

HERMAN: It was a pretty nice deal there, I would think, and turning into this place was—.
NELSON: Balboa was the longest—I think maybe I said that the other day--the longest Alice and I had ever lived in one place was that house at Balboa.

HERMAN: As I recall, when you came here, after you'd been selected and you came here, you were still, in a sense— I guess not in a sense, but you were still CO.

NELSON: Yes. I had not been relieved in Balboa, so between the 29th of June, when I became the Surgeon General, and the 8th of August, when I turned over Balboa to Admiral [Alberto] Diaz, I was both. When I came East, my deputy at that time was Mitch Harriman [phonetic], who's now CO of the hospital at Camp Pendleton. Mitch very competently ran the place for me for that time, which, in reality, he had been doing it anyway. You know, I'd kind of been the gray-haired guy that sat in the front office, and he ran the place. But between him and John Shore [phonetic], Captain John Shore, who's now CO of the clinic in Annapolis, John was my director in the Office of the Lead Agent. Between those two, they kept things running just fine. They were my two right hands, anyway.

HERMAN: But you knew you were in for something when you came here. You don't come to Washington without—there are issues that are brewing and things you're going to have to jump into.

NELSON: Well, it's kind of interesting. I got confirmed on Thursday night, whatever day in late June that was, by the Senate, confirmed me on Thursday night. I found that out Friday morning. We had a frocking ceremony Friday afternoon, with a faxed letter from BuPers saying I could be frocked. Some of my friends out there did it. My boss, I guess, if you will, the responsible line commander was Commander of Naval Base, San Diego, was Ronnie Frohman [phonetic], Admiral Frohman. She and my flag classmate, Vice Admiral Al Creckage [phonetic], who was Commander of Surface Forces in the Pacific at the time, the two of them, along with Alice and our son Raney [phonetic], promoted me, or frocked me on Friday afternoon. Then Saturday afternoon I caught a plane, and Monday afternoon we turned over, over here in the rotunda, between Admiral Harold Konig and myself, with fairly and reasonable informal for such an occasion, but Vice Chief Don [Donald L.] Pilling. Admiral Pilling was the officiating officer. And, yes, there were some issues. The CNO had some concerns about Navy Medicine.

Can I take a break?

HERMAN: Sure. Absolutely. [Interruption in recording]

You were talking about the issues that you had when you first arrived.

NELSON: I think I said the CNO, Jay Johnson, had a number of concerns about Navy Medicine. Some of them were perhaps well founded, and maybe some of them weren't. But nonetheless, they were not just his concerns, but they were concerns of a lot of the leadership.

There was a lot of unhappiness, particularly in the Medical Corps, a feeling of being ignored in some ways. There was concern that the graduate medical education was under stress because there had been an attempt to close some of the training programs at Portsmouth, which is a big fleet concentration area; and at the same time, they were looking at bolstering some of the training in some ways at Bethesda.

That's not a popular sort of move to make with the fleet, and there was no real attempt to involve either the fleet or the CNO in the decision-making to change those things, is what it seemed to me after the fact. That caused one heck of a big row, in fact got the Commander of Atlantic Command. At the time, it was still U.S. Atlantic Command, as I recall, but that was Marine Corps General Jack Sheehan [phonetic] at the time. Jack got engaged in it, and so did—they had a new Fleet Commander about that time, too, and he got engaged in it. That created a lot of unhappiness.

But the Medical Corps, things like the MEPSI [phonetic], Medical Education Programs Committee. I've gotten where I've said the acronyms so much, I've forgotten what it stands for. But it's really the part that looks at graduate medical education and how we do it across the Navy and really tries to make it make sense that we're training to what our needs are. They had felt like they had been totally ignored, because their recommendations had been kind of tossed out for a little while.

I don't know everything behind all that, but there was a lot of unhappiness, and unhappiness that we weren't taking care of patients, as many patients as we should be, around the system. A lot of that was troubling the CNO, and actually some of the dialogue that had restarted with us in the fall, I guess, late fall of '97, was surrounding some of that unhappiness of his. I tried not to feed it, but I listened. So I came in with somewhat of a mandate to take a good look at those things, and we tried to.

A number of things that we've had to wrestle with over time is . . . one of the things that had been set in motion was an attempt to prepare us for sizing ourself to what the THIXER [phonetic] requirement was. THIXR, and I never can remember what the acronym means, the words are that fill it out, exactly, but it's really our readiness posture. It's what's required from a medical standpoint in manpower and platforms to support the war plans. There had been an expectation that we were going to get driven to have only the manning required for THIXR. I don't know exactly, some of that came out of the 733 study and the like, I think. There wasn't anybody pushing us to do that at the time I came along, but nonetheless, that had been sort of how we were aimed.

There had also been a big issue over quality and concerns of quality, and the House Appropriations Committee had reacted to that, particularly Congressman [David] Hobson from Ohio, in whose district had been a fellow who had written for the *Dayton Daily News*. Mr. Corola [phonetic], as I recall, wrote some articles that were fairly scathing of military medicine, about how we paid attention to some quality issues.

There was a certain amount of truth in some of it. Anytime you're on a system as big as ours, you have some issues. But there was a lot of it, it never dealt in nominators; it dealt in

single cases of bad outcomes. Anyway, it really was not a good indicator of quality in the system. It was, maybe, an indicator of quality in a few cases. But nonetheless, that had put a lot of pressure on DOD Health Affairs to react to that somehow, and one of the reactions was to say, "We're going to do away with general medical officers," and that's where Navy Medicine was headed when I came into it.

I said, "Why in the hell are we doing this? Where's the quality indicators, the data that supports that?"

And so we went back and looked and actually did a study. We did a full study of where we had general medical officers, and then we did a decision, set up a study of what's the level of care required in these places where we've had general medical officers, what level of training is required, and what's the right kind of medical officer or independent corpsman or PA or whatever to put in those positions. And so we really did quite a study the first year, year and a half I was here to identify how many—or there's some of these places that didn't need anybody and were there others that needed a different quality. And we changed some of them. We changed some to family physicians or aerospace medicine or even occupational medicine, a few to emergency medicine or even internists.

But on the whole, it turned out we really did have legitimate need for a quality that—about 500--and some needed to be general medical officers. There were plenty qualified for it, especially those that we trained ourselves, because we include some operational medicine training in our own training programs for general medical officers, for interns in our own training programs. We documented this well enough that the task force that Congress, independent task force that they assigned to review the quality issues, agreed with us, and they made that report to Congress this year, that we had made the appropriate quality review and had well documented where we were, and we were at the right place. They never ever gave the number of how many GMOs we were keeping, but said we had the right process to know the right answer and that we had pursued it.

So we've taken that one off of the scope, because what I really found out was that when you look at that outcomes—and we monitor those very well in the Navy, better than they do in the private sector, by far. But when you took a look at all the data and went back and looked at JAG manuals and places where we had either reported somebody to the National Practitioner Data Bank or had had a limitation to privileges or something that indicated a potential quality issue, GMOs were not having quality problems in the practices they had. That was not where our problems were arising. When you took a look at it from a statistical standpoint, they weren't a problem.

HERMAN: Where was the problem?

NELSON: Well, you didn't concentrate any one place. You know, OB is always a place that is high risk. I mean, there's never a simple delivery. You always have to be prepared for a bad outcome or one that requires something special. That's a high-risk area, and so OB is probably one that has, if you're saying who has more than their share of risky things, OB. But when you take a look, how do we compare with the rest of the world, we're in damn good shape. We do very well. We have the best quality controls of any health care system. I'm convinced of that.

Anyway, all those were issues that we had to wrestle with. But the one that dominated

the most of my time since I've been Surgeon General has been resources. I came to town 29 June [1998], and at that time the other two SGs and I, along with Health Affairs, were looking at what would have been the FY '99—no, we were looking at how we were going to get by for the FY '98 budget and wrestling with distribution on that, supplemental, I guess, or reprogramming, I've forgotten. I think it was supplemental that year. And we had some real problems, and we were wrestling around that, and I said, "Well, what about next year? What are we seeing for next year?"

Well, it wasn't until in mid-July or later that we finally saw what the figures were. There had been a run through the president's budget out of Congress for how that distribution broke out for us individually for the direct-care system, what the dollars were, and, my God, it scared the hell out of me. We were really coming up short. We raised such a ruckus about that, three of us SGs, that the Congress got wind of it, and the House Armed Services Committee, Subcommittee on Personnel, which was headed—the chairman of that subcommittee at the time was Congressman Steve [Stephen E.] Buyer. He called for a hearing in August, late August. In fact, I had to come back from the COs' conference, come back for a day, because it was held in Norfolk that year. I had to come back for a day to participate in the hearings. But it was over the direct-care system budget, and that kind of started a three-year evolution of the direct-care system always being the source of funds to pay the contractors off for the managed care support contracts, and we've suffered these three years tremendously from it.

We have finally gotten the right attention, and the supplemental that we get this month for what was intended to be just thought of as a request by the administration to get us just to the end of the year, Congress has built it in a way that will augment us for next year. It gives us three kinds of money, and it directs it right at the direct-care system, to the SG's control, a portion of it. It gives us adequate dollars to end this year in good shape, but also gives us dollars then for some of next year, that'll carry into the next year's budget. And then it gives us a set of dollars that we can use indefinitely, and they're to do best business practices, do things that we've got a good business case analysis that says it will pay off. It fits right in. It's the things that we've been pushing in optimization.

If you go take a look at the words—which there's no reason anybody would, but I had reason to recently—took a look at what were my few comments when I came to this job, at the turnover I said one of our focuses had to be on optimizing our delivery of health care in the direct-care system. So what are we doing? We actually are doing optimization, and what this money from Congress, a part of that is really aimed at us using best business practices, and this money, to help us optimize the system. So we've finally been successful at something.

HERMAN: Did you have some special allies in Congress who really supported you wholeheartedly?

NELSON: Yes. One of the most consistent supporters has been one of the staff members to the Senate Appropriations Committee, the Subcommittee on Defense, and that's been Bob [Robert J.] Henke [Asst. Secretary for Management, Dept. of Veterans Affairs]. Bob was brand-new to the job about the same time I came to this job, and he spent a lot of time with us, and he made us show him what we do, how we do it, how we collect data and how—data quality and all sorts of stuff. He's not a pushover, by any means, but he's a strong supporter of doing

what's right.

And in that, two of the members of that committee have been ardent supporters, too. Senator Ted Stevens of Alaska has been the chair of that subcommittee, and was actually chair until the recent turnover of the Senate. He was the chair of the Senate Appropriations Committee, but he also chose to chair that Subcommittee on Defense. The other individual there was Senator Dan Inouye from Hawaii, who—the two of them, he was the ranking member, as a Democrat, on that committee at the time, and I suppose is again the chairman, since they just flip-flopped positions, I believe. [Laughs]

HERMAN: That's right.

NELSON: They have both been strong supporters of military medicine, and particularly of the direct-care system.

In the House this last year and a half, Ed Wyatt, who's a retired Navy Medical Service Corps Officer, has been the staffer to the chairman of the Subcommittee on Personnel of the HASC (House Armed Services Committee), he has been a strong supporter of us being supported and doing what's right. So there's been some strong support there.

HERMAN: And then you've had people like Congressman [Bill]Young, who's always out there ready to pounce.

NELSON: Well, let me tell you about Congressman Young, and hopefully I'll be fully retired before he hears any of this. Congressman Young is a two-edged sword. Congressman Young is the chairman of the House Appropriations Committee, and he also is a member of the Subcommittee of the House Appropriations, Subcommittee on Defense, so he has double influence here on us. He is a strong member here.

He has had a love/hate relationship, to some degree, with military medicine, and with Navy Medicine probably in particular. As you know, he had been a patient at Bethesda, and I guess it's open knowledge that he had cardiac surgery there several years ago, long before I ever came to town, and had a little bit of difficulty, in not outcome of the cardiac side of it, but outcome of some of the wound healing, and there was an IG investigation surrounding that.

And then he got engaged later on in care of some other patients and tried to assist them, I guess, in their access and their care, and not only just access, but how they got their care. Some would say that was major interference in health care. I think it was well intended, but I think it did interfere at times. Congressman Young and his wife, Beverly, are strong supporters of particularly our Marines, and particularly enlisted Marines, and anytime one of them is having health care problems, or think they're having health care problems, they're likely to engage. Some of his concerns, he and I sat down and talked in some detail—actually he, she, and I—in his office, and I would have had to agree with a number of his concerns. We might have disagreed on the degree to which they were an issue, but some of them were legitimate issues.

That became a big issue, because, I mean, anytime he feels angry at any part of the Navy, it has potential to have a major impact on all the Navy, and here we were, the CNO had a number of programs that he was trying to work through the chairman.

HERMAN: You need a lightning rod for that.

NELSON: We were the lightning rod, and that drove a decision by the CNO to do a special study of Bethesda. He gave me some direction on it, and then he directed who would lead that study and who the one of the members should be and some of the purpose of it.

Well, that study was done. Actually, at the time an awful lot of the change that needed to occur was already under way under the current commander out there, Rear Admiral Kathy Martin. But change is always hard, and Bethesda was going through what she called, and her staff then called, a transformation. Now it's starting to show a real positive outcome of that transformation, but change like that is hard. I went to Balboa and we did change, but we did not do it so rapidly as she chose to do it there. Sometimes you have to do it rapidly. I didn't second-guess her on that.

That drove a lot of unrest at the time, and the CNO was getting some feedback on that. But it pacified Congressman Young for the time being and let us get through that last year's budget cycle and some of the things, and get through, in fact, till recently. That report was finally completed to the current CNO's satisfaction, I guess. But I think any real actions that needed to be done have pretty well been instituted already by the folks at Bethesda.

Congressman Young, last time I talked to him, which was probably a couple of months ago, I guess, now, he was very pleased with what's going on at Bethesda, and, in fact, told me he wanted to hold a hearing before I left, specifically about Bethesda. I guess I looked at him with a shocked look on my face, probably, and he said, "No, I want it to be a good hearing, positive. They're doing great. It's that Walter Reed I'm worried about now." [Laughter]

HERMAN: Direct your anger at them for a while.

NELSON: I've been told that there's still a possibility, even though they go on recess the third of August, I've been told that he could still possibly, might call me back in September to such a hearing, because they come back the third of September, and I'm supposed to be arriving on the West Coast about that time. But he's well aware that I don't actually have a retirement date until 1 October, so—

HERMAN: So you're subject to recall.

NELSON: So I'm subject to recall, and actually even after that, if they were of such a mind, but probably less likely.

The congressional side of it and the politics of Congress—and it's not just Congressman Young, who I think basically has a good heart. It's the politics of the whole thing that really have tired me. I'm not a good politician, and I'm enough of an introvert that it's hard work for me to go play that side of it.

HERMAN: Pressing flesh and kissing babies is a very difficult thing to do if you're not—

NELSON: Yes. And if your heart's not in the issue that they want you to push, I'm too quick to tell them what I think. [Laughs]

HERMAN: I've always thought probably the worst assignment in the Medical Department would be either the Surgeon General or a combination of that and having to oversee Bethesda, because being the so-called president's hospital and the flagship, you can have the very best intentions of all, and it's like a powder keg ready to explode at any moment, regardless of what you do.

NELSON: Yes. There are a lot of issues that float around Bethesda, and I wouldn't want to be commander there. You know, it's the smallest, by far, of our big three, but yet everybody says, "There's our flagship." It's got that name, and it is called the president's hospital. The last president used it as his primary. You know, when he needed health care, that's where he chose to go, and many presidents have. Not every president, but many have. The current president, I don't know what he's going to use. The vice president uses George Washington, as I recall.

But Bethesda, some of the issues of Bethesda, we have a lot of really good people there, you know, the quality of practitioners there is great. Part of the difficulty has been attitude, because they believe their own hype part of the time and that they are the flagship and that they are the ultimate. They are a very important training hospital for us, and they're important to us because they provide the bulk of the staffing for the *Comfort*, the hospital ship. But that's the biggest reasons we need them.

But they've had a bit of an attitude problem that has pervaded the place for as long as I've known it, and I've been around it off and on for years. It has hurt them because their patients oftentimes sees them as elitist, particularly patients who float through town, the people who come for a tour here and come and go. If you're a retiree here, you think they're great, because you learn how to use them, and you learn how to use the system, and you learn who the practitioners are to deal with, and you don't deal with that stiff-arm part that sometimes the rest of the folks get on access and on just trying to accomplish things.

One of the things that I've insisted on with my own family is that they use the system, don't use protocol office, try to call the regular number for your appointments. I've finally given up on that, because we've got a contractor involved. I've used that system myself, and it doesn't work worth a damn. But that's not Bethesda's fault. That's contractor fault. But nonetheless, I've tried to get my own family to use the system that the first-class petty officer has to use, and when you do that, you get a different view of things.

I routinely go out there not in uniform, but in civilian clothes, and I look like every other old retired chief petty officer, and sometimes you don't get treated very well, and I've been accused of bad-mouthing, beating them up. But that's changed. I've watched it this last year. I think they've changed dramatically in a lot of their attitudes, and certainly their performance is improving. So I think their transformation is working, and I think it's doing what it needs to.

Now, from a health care standpoint, I've recently gone through, you know, before they let you out of the Navy, they look you all over pretty good, and they've got some wonderful practitioners out there and great people, I mean, just topnotch. So I think Bethesda's headed in the right direction. Now, some of their problems are that we—

[Begin Tape 4, Side 1]

HERMAN: In the medical department, I don't remember ever, really, any other CNO getting

that involved in medical matters, except when we were in trouble.

NELSON: [Laughs] Well, of course, because of some of that involvement that he had, he perceived we were in trouble at the time. That was his perception in '97, and I'm sure some of it came from those relationships with mid-level officers.

HERMAN: So he'd essentially be getting reports from their level. In other words, they perceived problems in their careers, and they would report to him directly and say, "We've got problems here in such and such," and he would respond to that.

NELSON: They probably wouldn't call up and say, "Hey, my boss is mistreating me." Some of their perceptions were probably right, I'm sure, but they felt under fire as a group, in some degree, particularly the Medical Corps officers that he communicated with. He used a network of acquaintances over time to kind of see what's going on around the system. And I'm sure he did that with more than Medicine, but I was most aware of the Medicine, because every once in a while he'd call me up or see me about something that I would think, "Now, that's kind of coming out of left field," and I gradually realized that there was probably some conversation he had had with somebody that stirred that. He sometimes wouldn't say directly, "I talked to so-and-so and they said—."

One of them, he called me when I was in Newport. Alice and I were up there partly for the CO training courses put on up there that involves not only medical, but all new COs and their spouses. And so Alice and I were invited up to participate in some of that, and I got call from the CNO, Admiral Johnson. He chatted around a little bit, and he said, "Dick, so-and-so is retiring. Do you know why?"

I said, "Well, I know he's retiring," because I'd talked to him. This was an individual that I'd known for years. I had talked to him a few months before, but I couldn't remember the details at that point of why he had said he was retiring.

He said, "Well, he was my whatever physician sometime back. Why don't you check out what will it take for us to keep him from retiring?"

Well, the guy was in a specialty that could draw big bucks, for one thing. I mean, you can create all sorts of reasons, excuses for why you're retiring, but sometimes there are other things in it, too, which occurred with a different friend of his another time. But this fellow, I called him up and talked to him, and the whole thing was, Admiral Johnson knew what his stated reason for retiring was, and it was one of the issues that we wrestled then for some time after that over relationships between nurses and doctors, CRNAs and anesthesiologists. That was a Bethesda-centric issue. I'd had two previous hospital commands where those relationships worked very well between those two, and everybody knew sort of their role, their competence, the freedom that they had as licensed practitioners.

But anyway, he would come at things with—you had to learn that there was probably more to the story than the initial question that came out.

HERMAN: Why would he have tracked you down in Newport to ask you that question?

NELSON: [Laughs] It was more than a casual interest. But I've got to say that he, even

though I disagreed sometimes with his way of getting information, or getting what he thought was good information, but I appreciated his interest, and I appreciated that at least he would listen to me to discuss the issues. Even though he might have jumped pretty forcefully to a conclusion, you could argue with him some. You had to be judicious about how you did it, which I wasn't necessarily, but we could discuss those things. So in a lot of ways, he was a very supportive CNO and certainly gave me a fair amount of freedom, and I appreciated that.

One of the things that kind of came out of that interest of his and that focus on needing to make some positive changes, as he saw it, in medicine was that I got a lot of attention from he and the Vice Chief, Admiral Don Pilling, and it was very positive. Don Pilling and I developed a very good working relationship. I would hear out of him, probably the first six months I was here, I heard out of him essentially every day, sometimes three or four times a day. They would be calling about some issue. Either the CNO or the Vice Chief, I heard out of essentially every day for quite a while, and then it backed off.

HERMAN: You've had a pretty close relationship with Admiral Clark. You fellows knew each other.

NELSON: Well, I've known him in the past, and with him, really he has been very standoffish from medicine. He's been distracted by all the things that have gone on since he's been CNO, and so he has really stayed at arm's length from medical issues. But that can be good and that can be bad. The downside is, we don't perceive that we have the opportunity to really give him a good strong brief on the issues of medicine. I get an opportunity to say something at morning meetings, but so far he has not had the degree of interest, and with that maybe the degree of concern, that Jay Johnson had about medicine.

But Admiral Pilling was a great guy to work with. He's a Ph.D., very bright. I don't know; we just hit it off really well and could joke with each other, kid about things, even kid about what stance the CNO was taking on an issue at the time. [Laughs] But it was a good interchange, and probably of all my Navy bosses, he's one of the two favorites. In this job, we day to day work for the Vice Chief, and I really developed a trust and a like for him.

He had not had such an engagement in medicine before, other than he had been N8, which he'd spent his life in the money business, and in that role he had regularly tried to take money away from medicine. [Laughs] And so now he had responsibility for it, and he started to see what condition he had left it in.

HERMAN: I've got an Admiral Pilling story that— [Interruption in recording]

NELSON: Well, my outcomes with Admiral Pilling were a little better than that.

HERMAN: Hopefully, they were better.

NELSON: He really developed an interest in our issues, and since part of our issues were money, he had a keen understanding of that. He volunteered to be the first chairman of the DMOC, the Defense Medical Oversight Council, and was a strong leader of the efforts of that group to review military medicine and review kind of the whole scope of it.

He got into it enough that one day he and I were talking about the differences in the services as to what portion of their medical department staffing was directed at the wartime requirements. I said, "I feel fairly good about the Navy. We're right around, 85 percent of our manning is wartime required. They have a platform. The Marines, they have something that we're assigned to, and the rest is needed for training programs, for our—balance out care of the patients in peacetime."

He said, "Well, you're wrong. It's not 85 percent. It's 92 percent. I've checked this out." [Laughs]

HERMAN: He was involved.

NELSON: And he said, "Do you know what the Army and the Air Force are?"

I said, "No, I don't, exactly. I've never been sure about their numbers. I don't think they're as good as ours."

He said, "No, they aren't. The Army is 71 percent, and the Air Force is 52 percent." Anyway, I mean this guy went after the numbers.

One of the things that he recognized and one of the things that was a turning point in his decision to really get engaged in military medicine was, if you'll remember back in, I don't remember if it was late '98, early '99, it must have been early '99, there was a big push to add what the administration called $112 billion to the defense budget over the future years defense plan, five-year defense plan, and there was really a lot of work went into justifying that and getting that well identified to what it was. But after the fact, that was done by the Joint Chiefs and the chairman came up through the services. But there wasn't a thing in there for medicine, and after the fact it occurred to him all of a sudden in one of our discussions that they'd done all this stuff, but because they weren't responsible for medicine financially, it hadn't even occurred to them to put something in for medicine. And Health Affairs, which was the advocate for the Defense Health Program, seemed to be oblivious to the goings-on and to get inserted in [?]. So he recognized that the line had re-engaged in medicine, and from an oversight standpoint more than just a personal interest standpoint, and he really led that charge.

It made enough of an issue out of it that, between the squawking of the SGs and folks like him kind of agitating with the Vice Chiefs, it caused the Undersecretary of Defense at that time, Dr. John Hamre, to call a health care summit sort of thing. So we started on a Friday evening, as I recall, and then returned on Saturday. It had the Vice Chiefs, the Surgeons General, folks from Health Affairs, I mean, HA—that was Dr. Bailey, Sue Bailey at the time—plus folks from—not many folks, I guess—had the Comptroller there, Bill Lynn [phonetic], and a couple people from PA&E there. We went through all the resource issues and the various things of health care, and out of that—and one other person that was there was the Undersecretary of Defense for Readiness and Personnel. P&R, Personnel and Readiness, I guess.

That was the beginning of a closer look at military medicine. Dr. Hamre had been the Comptroller in the past, and he knew that they had shorted medicine. He finally admitted that. In Bill Lynn's last month or two in office, he admitted that. Of course, these guys all try to admit it at the tail end of it, when they aren't going to do a damn thing about it. But that was the stimulus for creating the DMOC. That's what Admiral Pilling volunteered to be the chair of, first chair. It was a co-chair thing, the chair and a co-chair. The co-chair was to be the

Undersecretary of Defense for Personnel and Readiness, and at the time that was Rudy DeLeon. Rudy wasn't very excited about all this, in my opinion. Now, I've got to tell you, it's my opinion. Rudy tried to delay it, and it finally took some pushing from the SGs and the Vice Chiefs and all that to get it off the dime and get us actually organized.

It's kind of an interesting pull and tug, I guess, between the civilian leadership and the military leadership, and it became obvious—has become even more obvious over time in the attempt of how you oversee the health care programs and the benefit, and, in fact, has led to the demise of the DMOC. I attended the last DMOC meeting last Friday. The current head of it, chair since Admiral Pilling retired, has been General [John M.] Jack Keane, the Army Vice Chief. I've known Jack since we attended the Capstone program together back in summer of '91, and we've interfaced a few times since then. But he was the final chairman of the DMOC.

DMOC did a lot of good stuff. But it was campaigning, at least the military part of the DMOC, was campaigning for a restructuring of military medicine, from a standpoint of its leadership and how it reported, and it really wanted to put a four-star line in charge of it, in a joint job that would report to the chairman. That was not palatable to the civilian leadership. And we've got a compromise coming that I think was worked by Dr. David Chu. Dr. Chu will meet monthly with the Surgeons General and the Assistant Secretary of Defense, Health Affairs. And then he will also meet, on I think that same regularity, in a separate meeting with the Vice Chiefs to talk about policy and oversight issues in medicine. So it's a change in how it's done, but it makes it more clear that Dr. Chu is in the driver's seat.

I'm more comfortable with him in the driver's seat, I think, than I have been during much of my tenure as SG. But that's an interesting sidelight on some of the politics of the tension between the military and the civilian leadership. During the first two-plus years of my tenure as SG, we had a bit of a leadership void at the top of military medicine, and that caused us considerable difficulties, in my opinion.

Enough on that subject. [Laughs]

HERMAN: This has obviously been a consuming issue for your tenure. If you look back at the last three years as SG, I'm sure you've had your headaches, considerable headaches as far as resources and those types of things. What have you considered to be some of the greatest moments of accomplishment?

NELSON: I don't know. I'll tell you the things that make me feel the best. I always felt kind of buoyed-up when I visited our Navy men and women, Navy medical men and women in particular, at work, around wherever they worked. If I went to NAMRU-3 in Egypt and went with them out where they were doing studies in the Nile Delta and watched what they were doing and the impact they were having; if I talked to our researchers who were working on the malaria vaccines, DNA things, the DNA vaccines that will change the future; and if I go to one of our clinics, dental or medical clinic, and see them treating patients and see the enthusiasm our people have; those are the things that always made me feel good. I mean, you could get instant gratification just watching and knowing that—it made it worthwhile to come back and face the political and the resource issues and made you feel they were worth fighting those battles if you went out and saw the good that people were doing with what little resource you were able to give

them.

We have tremendous people in Navy Medicine, supporting the Marines and the sailors, and supporting the other services, too. Seeing them and listening to them and supporting them were the things that gave me joy.

Now, there are things that I've felt good about. I think we've made a lot of progress on operating in a more businesslike manner. We really have a pretty solid strategic plan that we have worked hard at and have worked to have goals in it that we could work at on an annual basis, and we've made great progress, and we've developed metrics to really follow that progress and know how we're doing with it. We are improving our data quality to the point that we can use our own data to make business decisions. It's not perfect yet, but we've got progress under way to make it really functional.

We are doing a better job of being able to track our readiness, our readiness in our deployable platforms, and we're trying to see that we are in line with where the Marine Corps is going for future roles for the Marine Corps and that we medically can meet that. We aren't there yet, but they're not there yet, either.

So we're paying attention to business, the business of peacetime and the business of war. So I feel good that we have improved the tools to make decisions with, and I think that's been a big accomplishment of folks.

A part of that is what we've called optimization. We aren't perfect with that by any means yet, but we've even got Congress talking about it. I was just reading a letter today from Congressman [John] Murtha, the ranking member of the House Appropriations Committee, particularly the Subcommittee on Defense. Mr. Murtha was talking about optimization and the importance of it and the intent of Congress, with the recent supplemental bill, that a portion of that was specifically directed for the SG's use in optimization. He was directing that letter to Secretary Rumsfeld.

We've really got people attuned with how we're trying to accomplish our mission, peacetime health care, and now that they're resourcing it, I think there's nothing going to be standing in our way of really doing what we need to be doing and what our practitioners want to do, which is really take care of the patients. So I feel good as I leave about the position that we're leaving Navy Medicine in. We've got our problems, but I can see that there are solutions coming.

The CNA (Center for Naval Analyses) study we did, some of what brought me to office was the discomfort of senior leadership with how our practitioners were feeling about themselves, and thus what might be affecting retention, and I came with some of that concern myself, having been a Commander in Balboa for so long. And so I asked CNA to do a study on provider satisfaction, and part of that, retention. They did a very good study on it. They came up with what a number of the issues were. Some folks said, "Why in the world did you bother doing a study? We could tell you what the issues were." Well, yes, I wasn't too surprised with what the issues were, but it gave me credibility with saying what the issues were. I had an outside group look and tell me what the problems were.

HERMAN: CNA has a reputation for doing that kind of work.

NELSON: They don't ask you to like what their product is. You just have to recognize that

it's a quality product. The answers they gave me weren't surprising, but I was able to take that to Congress and say, "We've got problems, and a good bit of it is money." [Laughs] It's both money for the direct-care system to provide the practitioners what they need to do their jobs, and it's also to provide them—we're not trying to match the public sector in income, but yet we ought to give them a fair remuneration for what we expect of them. CNA documented that very well, and that has even Congress thinking back and ask for a full study by CNA for all the services. So our push was a stimulus for that, and my expectation is that this next year Congress will enact some legislation—I shouldn't say legislation, but maybe it'll be a change in legislation, but at least a review and updating of the pay issues for practitioners. So I feel good about those things, and I'm encouraged for the future by those things.

HERMAN: You've had, what, thirty-four years in the Navy?

NELSON: Yes.

HERMAN: You look back at it all, and it seems to me, from what I've heard here, that you've really enjoyed your career in the Navy. You've really had some moments.

NELSON: Well, you've kind of given me the opportunity to relive some of that. It has been a quick thirty-four years, looking at it from this end, and it's been a lot of fun. You know, there are parts of it that I, at the time, did not enjoy. But in retrospect, they probably made me a better leader. My time at IG was a painful time, but it probably made me look at things a little bit differently.

One of the things that gave validation, I think, to Navy Medicine and to how we do business and how we're organized and how motivated our people are was the recent Naval Inspector General review of BuMed. You've been here a number of years, Jan, and you know that it had been ten years since the Naval IG had come to BuMed. That worried me, and it worried me about what the possibilities were of how they would look at us and what they would dig into and the like. I didn't have any issues on the top of my head that I thought were problems, but when it's been ten years, a lot of stuff can flow under the bridge, and some of it get caught up.

But the IG inspection, they never quite write it in their report, but they said we were the best functioning Echelon 2 Command that they had inspected in any recent memory of theirs. And, in fact, we're getting the way we do our resource accounting and the way we track our resources and the data that we use to follow that and how we use it and how we direct it and all is being touted as the Navy standard that others should use, and even the new Undersecretary of the Navy brought that up to me in a meeting we had with the Secretary here a month ago or such. She was well aware of it. We're getting calls from around the Navy about what is it we're doing and how are we doing it.

HERMAN: That's something to have.

NELSON: Yes. I think that gave validation to what we thought we knew, and that was that Navy Medicine does have it together. When we say we've been underfunded for the entitlement

that we have responsibility for, I think we've got new credibility in people believing that we really do know what we're talking about. So those things I feel good about. I mean, that's not a personal accomplishment. That's an organizational accomplishment that comes over time.

I've been a strong believer in, I guess, some of the theories of Dr. [W. Edwards] Deming and others, and folks since then, on the work in continuous improvement and performance improvement. I've pushed that in the commands that I've had, and we've done that here at BuMed, and I think you see the results of that. The interaction of the deputies at BuMed now—you know, Jan, as you know and we've talked about here, this is my fifth job here on this hill, I guess. I've spent a total of nine years here over my career, starting in '71. It was always a collection of fiefdoms, sort of. The communication between codes, we were stovepipes, sort of. Well, we've still got some stovepipes, but we've got the best communication going at the top ends of those stovepipes that I've ever seen.

We've got a deputy's council. They meet every week, at least weekly and sometimes more than that, to go over issues and talk things, and it's become a real productive meeting. I had one of the deputies stop me the other day and tell me what a change they had seen in that process these last couple of years. Even the IG saw that and saw what an impact that had and how that changed the whole interaction between the codes, because there were people that understood each other's business across code lines at the top. So I feel good about that sort of thing.

One of the other things we've done that I feel positive about is, we've organized the corps chiefs. They are not stovepipes anymore, either. They each have their responsibility for their own corps, but we meet on a regular basis—been meeting on about a monthly basis—to talk issues jointly, corps chief issues. So it's myself and the corps chiefs and their deputies, and we get together and we talk everything from CO/XO screening to selection of folks for CO/XO jobs and how we identify OIC jobs. One other person who's engaged in that is the senior person, the medical detailer at BuPers. That had been Ralph Lockhart [phonetic]. Now it's Dick Fletcher.

We're trying to do things more aligned, if you will, to use one of the CNO's favorite ideas. We've really tried to align how we do business between the corps and with the corps, with the people in those corps, so that we've taken the competition out of it and tried to do that at the top so that we're treating everybody fairly. The corps are more aligned and more engaged with each other, the corps chiefs and their deputies than ever before, too, or at least in my time. So I feel good about that.

HERMAN: Not bad for a guy who's a draftee, huh?

NELSON: Isn't it amazing a draftee could come in and screw it up that bad?

HERMAN: It seems like you did pretty well. Well, thank you. [Tape recorder turned off]

NELSON: I had never written any notes down or anything when you and I talked before, but after this morning I remembered where we stopped, sort of, and I jotted down a few things.

One of them, we talked a lot about Bethesda, but we didn't talk about Portsmouth. When I came to this job, Portsmouth was the one I was worried about. They seemed to be lagging and having their problems, and having some row problems and also problems in just getting the

patients seen, and they were really dragging on getting into the new facility down there. I paid several visits to them, and I also, early on, visited the Commander-in-Chief of the Atlantic Fleet. [Pause] Good grief—I'm trying to remember his name.

HERMAN: Recently?

NELSON: Yes, it's [J.]Paul Reason , Admiral Paul Reason. Paul and I had been acquaintances going back several years, so we were friends. I called on him, and we were discussing these things. He invited me to lunch. It was a nice lunch, as you'd get occasionally—that you missed. [Laughs] Anyway, we were talking, and I was expressing my concern about the lag on getting into the new hospital and the impact of that, and he said well, he had some personal experiences with the impact of that and how that was impacting people, that lag, and he wanted to do something about it.

We were talking about it and what could we do to move that up on the move-in date, and he said, "Well, we'll just set a date." He sat there a minute, and he said, "The sixth of January." This would have been the sixth of January, [pause] I guess it would have been the sixth of January '99. He said, "That's a new year, a new week." He had several things that were about that date. And he said, "That's a stretch goal, but," he said, "let's tell them we're going to open it that date, and they can get it ready," because I had walked away that day and they'd told me it was going to be October or November, at the earliest, before they could do it.

HERMAN: In '99?

NELSON: Yes. I think I've got my years right here. Anyway, he said, "We'll just give them that date." And so he did. [Laughs] Oh, my God, you never heard so much gnashing of teeth when he did that, but I'll tell you what, they opened in April. They opened it in April. [Laughs] I mean, he got six months out of them. A lot of folks would deny that that was what influenced it. And he got them some of the help they needed to complete it. But they had a lot of pride in themselves when they opened that place then and got it done earlier, and they did a very good job opening it.

During that time, I had a lot of concern about the approach of the leadership, I guess, down there and how they were preparing themselves first to really do business in the new facility, do health care, clinical care, and do it in a business-like fashion, and I had concerns about how they were interacting with—how the work was going with their contractor, because they had a new contract. I had several sessions with what they called their board of directors down there, I guess, board of directors, and their Commander, and in one of them, first I told the Commander, and then she said, "Would you come tell that to my board?"

[Laughs] I said, "Sure, if you want me to." I told her that the dissatisfaction with the functioning of the command was getting to the point that one of us was going to get fired, and I would try to see that it wasn't me, that we had to do something.

So I went and explained to her staff, that senior leadership there, that they needed to get that functioning in a more business-like, performance-oriented manner, with the resources at hand, and they needed to be recapturing patients and getting their clinicians happy with their work; and if they couldn't do it, I would hunt around the Navy to find people who could.

That's a harsh kind of thing to have to tell people, and I don't enjoy doing that and have limited the number of times I've done it. But, you know, that place turned around. I can tell you that in 2000 they were the most productive—in fiscal year 2000, they were the most productive medical center in the Department of Defense.

HERMAN: In the whole department?

NELSON: Yes. By a few numbers, they beat San Diego.
HERMAN: That's quite a distinction.

NELSON: It was an amazing change, when you look at the difference between their fiscal year '99 performance and their fiscal year 2000 performance; and when you took a look at patient satisfaction and the like, it jumped. Now, you know, they got into their new facility. They did a wonderful job of opening that and of getting started in it. And they took some pride in who they were and what they were doing, and it showed through to their patients. So I was pleased with their response to having the issues kind of giving them an ultimatum, in some ways.

On the other hand, I did a little bit of a similar thing with Bethesda. I had gone out and talked to their leadership several times and talked to their, I don't know, 75, 100 senior folks on a couple of occasions and talked about the changes in health care that they to get in line with, and there was a certain amount of interest, but not a great deal.

I gave them a challenge, which Kathy Martin and her board of directors, it took a while to get their attention, and it got some of them awfully mad at me, but that helped stimulate them to do their transformation. I've still got some senior people angry at me, but they're changing the way they do business. And it's hard to do here, for the reasons you and I talked about, they live in a tough environment. But they are starting to change the way they do business. And they got a bad contract. The managed-care support contract there is the worst of all the ones we have.

HERMAN: I've heard terrible, terrible things about that.

NELSON: That's the worst performance we have, and I've said for three years that we should get rid of it.

HERMAN: How do you get rid of those?

NELSON: Well, that's the responsibility of the TRICARE management activity. It's a difficult issue to deal with, but you can't have a contractor you can't trust, and you shouldn't have.

HERMAN: I've gotten universally bad reports of people trying to get appointments and getting treated poorly over the phone.

NELSON: I have called for appointments myself, for myself. You know, I tell you that I expect Alice to look after getting her own access to health care. Well, I do mine, too, most of

the time, and it's impossible. I have never gotten a satisfactory scheduling out of the contractor. I've usually had to give up and go call in to individual departments out there, clinics, to get appointments. And that's unfair to our patients, it's unfair to our providers at Bethesda, it's unfair to our system to have to put up with that kind of thing. I've voiced that very loudly, and did it again last Friday. [Laughs] I think we have folks now that may listen, so I'm hopeful for the future of that group. But it has taken us too long to address it.

HERMAN: Thank you. Thank you very much.

[End of Interview]